



***Recommendations of the  
OxyContin and Heroin Commission***

***Commonwealth of Massachusetts***

***November 2009***

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Commission Members	Organization Affiliation
<i>Legislative Appointments</i>	
<b>Senator Steven Tolman, Chairman Appointee of the Senate President</b>	Senator, Massachusetts Senate
<b>Senator James Timilty Appointee of the Senate President</b>	Senator, Massachusetts Senate
<b>Senator Scott Brown Appointee of the Senate Minority Leader</b>	Senator, Massachusetts Senate
<b>Representative Brian Wallace Appointee of the Speaker of the House</b>	Representative, Massachusetts House of Representatives
<b>Representative Martin Walsh Appointee of the Speaker of the House</b>	Representative, Massachusetts House of Representatives
<b>Representative Jeffrey Perry Appointee of the House Minority Leader</b>	Representative, Massachusetts House of Representatives
<i>Gubernatorial Appointments</i>	
<b>Michael Botticelli</b>	Director, Bureau of Substance Abuse Services
<b>The Honorable David Capeless</b>	Berkshire District Attorney President, MA District Attorneys Association
<b>Dr. Douglas Ziedonis</b>	Chair, Department of Psychiatry, University of Massachusetts Medical School & UMass Memorial Health Care
<b>William Luzier</b>	Executive Director, Interagency Council on Substance Abuse and Prevention
<b>Patricia Horne</b>	Deputy Director of the Office of Community Corrections
<b>Dr. David Hoffman</b>	Medical Director Metropolitan Boston Area of the Department of Mental Health
<b>Terre Marshall</b>	Assistant Deputy Commissioner of the Department of Correction
<b>The Honorable Rosemary Minehan<sup>1</sup></b>	Massachusetts Trial Courts

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<sup>1</sup> In accordance with § 4C(2) of the Code of Judicial conduct, Judge Minehan was prohibited from participating in discussions pertaining to law enforcement, corrections or clinical policies and issues which are the concern of the Executive and Legislative branches of government. For a copy of the Supreme Judicial Court, Committee on Judicial Ethics Opinion see Appendix A.

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## Executive Summary

The Commonwealth is in the midst of a serious and dangerous epidemic. Prescription drug use is skyrocketing, opioid overdose deaths are steadily increasing and while support for these addiction treatment programs has increased, it is not sufficient to meet the needs of this growing problem.

The Massachusetts OxyContin and Heroin Commission was established under Chapter 302 Section 56 of the Acts of 2008 by the Massachusetts State Legislature to investigate and study the impact of the OxyContin and heroin epidemic on the state and municipal governments and recommended policy solutions to help stem the tide of this epidemic.

Between 2002 and 2007 the Commonwealth lost 78 soldiers in Afghanistan and Iraq. In the same time period, 3,265 Massachusetts residents died of opiate-related overdoses. The Commonwealth is losing men and women on its streets at a rate of 42 to 1 compared to what the state is losing in two wars overseas. Addiction is a medical disorder, and we have a public health epidemic on our hands that is larger than the flu pandemic. If the H1N1 virus killed 3,000 people in a five year period in Massachusetts, the crisis would be center stage and the entire Commonwealth would be working to find a solution to protect the public. However, because of the stigma surrounding substance abuse the opiate epidemic is left in the shadows and little light has been put upon reforming the policies involving substance abuse in the Commonwealth.

In 2005, 21.8 percent of the total state budget was spent on substance abuse and addiction related programs.<sup>1</sup> This funding represents a broken system as 202 people entered an ATS treatment program over 10 times in 2007.

- In 2007 there were 105,552 admissions to DPH-funded substance abuse programs in Massachusetts.<sup>2</sup>
- The total amount spent on substance abuse and addiction in the justice system in 2005 was \$1.084 billion, which was 5.3 percent of the state budget.<sup>3</sup>
- Nearly 70 percent of inmates in state and local prisons throughout the country admit to regular drug abuse.<sup>4</sup>

The cost of opiate addiction is seen in the families who deal with the disease each day and in the increasing costs to the state. The pain and heartache that this disease inflicts on families across the Commonwealth is widespread. It appears that regardless of socioeconomic status, race, religion, or sex, the disease of addiction is devastating families at an alarming rate. Throughout the Commission hearings family members and loved ones provided some of the most powerful evidence of this terrible problem. Our understanding of the problems surrounding addiction and the new wave of prescription drug abuse is constantly evolving and as a state we have a duty to our citizens to provide comprehensive programs and treatment for those affected with this terrible disease.

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## ***Summary of Recommendations***

In looking at the specific problems with OxyContin and heroin abuse, the Commission was able to tailor its recommendations to the particular concerns surrounding opioid addiction. Substance abuse affects each individual differently and there is no single solution to ending opioid addiction in the Commonwealth. The Commission believes that there are a variety of steps that can be taken to improve the prevention, treatment, safety and long-term outcomes of this devastating disease. Thus, the recommendations that are made in this report offer the widest array of policy solutions.

Based on the nearly 30 hours of oral testimony, thousands of pages of written testimony and the many heartfelt stories the Commission received, the recommendations reflect twenty broad areas of public policy pertaining to addiction and treatment of addiction. The major points of reform include; improving education and prevention measures in schools, revamping our prescription monitoring program to fall in line with more comprehensive plans from other states, regulating pain management training for doctors, dentists and nurse practitioners, ensuring that health insurance companies cover the necessary treatment for each individual, implementing a comprehensive jail diversion program for first-time, non-violent offenders, developing more effective strategies to support long-term engagement in treatment, and correcting the CORI system to better reflect the nature of substance abuse related crimes.

### **I. Massachusetts Prescription Monitoring Program**

One of the most efficient ways at the state level to stop fraud, and reduce the availability of dangerous prescription drugs, is an active and effective Prescription Monitoring Program.

- a. The Massachusetts Prescription Monitoring Program should be overhauled so that it is a useful resource for the many state agencies, and non-governmental entities that have a stake in the careful monitoring of pharmaceutical distribution.
- b. The Commission believes that if the Department of Public Health is unable to assist in making these overwhelming changes in the PMP, the system may need to be moved to another regulatory agency.

### **II. Pain Management Training and Education**

The Commission believes that educating our doctors, dentists, physician's assistants, nurses and pharmacists is a major tool in fighting the legal prescription drug abuse trade.

- a. Continued support of the use and development of evidence-based educational materials for teachers, law enforcement and other health professionals.
- b. Improved training on the identification and intervention of prescription and illicit drug abuse.
- c. Improved pharmacy training on the identification of prescription drug abuse and the security measures necessary to deter such abuse.

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### **III. Tamper-Resistant Prescription Pads**

Implementing a fraud-resistant prescription pad program would allow additional safeguards to be built into the prescription delivery system without incurring major additional expense or creating a major disruption to the system saving the Commonwealth millions of dollars in counterfeit prescription costs.

- a. The Commission recommends that all prescriptions for controlled substances be written on official state prescription pads, which contain tamper resistant features, and that no exemptions to this rule may exist.

### **IV. Preventing Overdose Deaths with Limited Liability Legislation**

Limited liability legislation would provide limited immunity from drug possession charges and prosecution when a drug-related overdose witness or victim calls for medical attention.

- a. Sensible Good Samaritan legislation should be enacted similar to New Mexico's that will be effective in decreasing the number of overdose deaths.

### **V. Overdose Prevention for Minors**

Under current statutes and regulations, minors can check themselves out of the hospital and a parent may never be informed. This has obvious consequences for both the minor and parent and leads to a complete breakdown in communication.

- a. The Commission urges that legislation be enacted to mandate that hospitals report to parents in the event of a minor overdose and enable parents to take the necessary steps to seek treatment for their child.

### **VI. Case Management**

Case management could provide some of the necessary supports to assist individuals with substance use disorders in moving through a difficult process with many obstacles.

- a. The Commonwealth should further investigate the state's capabilities to provide case management services to individuals identified with a substance use disorder.

### **VII. Insurance**

The Commission understands the current climate in which Massachusetts finds itself in and the overwhelming support for cost containment and reform in the health care industry as a whole.

- a. The Commission recommends strengthening Federal and state mental health parity laws to limit loopholes and provide comprehensive services in the form that is best suited to the individual suffering from substance use disorder.
- b. Mandating a medical necessity definition which includes a determination for behavioral health issues, providing for consistency across the state.

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- c. Ensuring that should an individual chose the course of treatment that requires medication assisted treatment, proper coverage by insurance companies be mandated through the state.

### **VIII. Addiction and the Criminal Justice System**

The Commission recommends that probation supervise post-release so that the substance abuse treatment afforded through the Community Corrections Centers (CCCs) can be implemented for a time duration that is consistent with evidence-based practice.

- a. Adopting practices such as the Bureau of Justice Assistance's Sequential Intercept Model, where interventions can occur at any and every point along a person's involvement with the criminal justice system.
- b. Enacting mandatory post-release supervision that could compel a person leaving prison into treatment.
- c. Sentencing reform should include a variety of components, those which allow the Department of Correction to "step down" inmates through the various security levels prior to release.
- d. Enhanced residential and outpatient substance abuse treatment programs which are essential during incarceration.
- e. Permitting substance abuse intervention not only for probationers who are "sentenced" post-disposition but those who are awaiting trial and under pre-trial probation supervision.
- f. Additional substance abuse treatment intervention through the reintroduction of "split" and "suspended" sentences to state prison adjudicated in the superior court.

### **IX. Jail Diversion**

The Commission believes that we must drastically alter the manner in which we deal with those suffering with substance use disorders before they enter our criminal justice system.

- a. The diversion of first time, low-level offenders from a correction setting into treatment is the best first step towards reforming a system in dire need of attention.
- b. A jail diversion model requires up to 90 days of inpatient treatment, followed by a year of case management and support.

### **X. Interdiction and Law Enforcement**

Law enforcement officials play an important role in the substance abuse equation as they are often the first responders in instances of illegal activity and play a crucial role in the implementation of policies throughout the Commonwealth.

- a. The Commonwealth can be better served by improving the methods of communication with federal enforcement agencies responsible for targeting internet suppliers which are often found to be the route source for expansive criminal enterprises.
- b. Improving educational awareness and providing access to the Massachusetts Prescription Monitoring Program (PMP) would be the next step in the drive to better



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equip our law enforcement professionals to fight prescription drug abuse and illegal activity.

#### **XI. Long-Term Treatment**

Long-term treatment programs are needed in the Commonwealth to provide a continuum of care for individuals with substance use disorder.

- a. The Commission recommends that a comprehensive approach to long-term treatment, providing individuals with comprehensive substance abuse monitoring, case management, support groups, pharmacotherapy and behavioral therapy.
- b. Additionally, long-term treatment must include family and child care services, vocational rehabilitation, mental health services, housing, financial and medical services.

#### **XII. Education and Prevention**

The Commission believes that raising awareness about the harms of drugs, alcohol and substance abuse is an issue that must be addressed at an early age.

- a. Given the changes in substance abuse in the Commonwealth, drug awareness programs must be updated to include illicit drug use such as prescription drugs.
- b. A statewide program should be implemented to require the program throughout all levels of a child's education, including the upper grades of elementary school.
- c. Licensed drug and alcohol counselors should be present in each middle school and high school throughout the state providing diagnostic services and referrals for students with substance use disorders.

#### **XIII. Recovery High Schools**

For many students suffering from substance use disorder, having an environment such as a recovery high school provides them with a safe haven, where they can both learn the state mandated curriculum and receive proper addiction treatment.

- a. The Commission recommends that the state continue to support recovery high schools, by increasing the number of recovery high schools in the Commonwealth through more funding and legislative support.

#### **XIV. Disabled Population**

The Commission believes that as with all substance abuse issues, treatment must be individualized and must adapt to meet the needs of specific populations, such as those who are also physically disabled.

- a. Vocational rehabilitation counselors and social service case managers need to recognize and address substance in their clientele and increase referral to treatment.
- b. Provider sensitivity to treatment barriers training (political, attitudinal, or physical) is crucial while devising evaluations and individual treatment plans.
- c. Treatment programs will need to address the attitudes of their staff and improve accessibility of their facilities, policies, and materials.

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- d. Substance abuse treatment professionals must pay close attention to the unique aspects of the lifestyle of persons with disabilities, which may affect the outcomes of substance abuse treatment.

#### **XV. Co-occurring Mental Illness and Addiction**

Co-occurring disorders place additional restraints on the treatment and recovery process and deserve special attention for the type of treatment required.

- a. The Commission would recommend implementing lessons learned from the SAMHSA Co-Occurring State Initiative Grant (COSIG) that evaluated how 17 states addressed the common problem and developed more effective ways to identify and treat individuals with co-occurring mental illness and addiction (dual diagnosis).

#### **XVI. Cultural Competencies**

The Commission were struck by the lack of information about the problem which this section discusses and, similarly, about the lack of suggested solutions.

- a. The Commonwealth should increase support for the worthwhile translator services provided by the Commonwealth and improve access for those who need them.

#### **XVII. Veterans' Issues**

The Commission recommends continued funding support for veterans outreach, referral services, and the Department of Veterans' Services.

- a. The Commonwealth must continue to improve upon its methods for identifying returning veterans so that they may benefit from the services available to them.

#### **XVIII. CORI/Job Training**

An integral part of recovery is reintroducing those who have recovered from addiction both into society and the job market. This process is stymied by the inability of former substance abusers to find work because of CORI offenses, even after they have shown that they are rehabilitated and are making every attempt to stay sober.

- a. Increasing funding of the Correctional Recovery Academy (CRA) and other programs that focus on treatment and reentry.
- b. Mandating a program for Certificates of Rehabilitation and Recovery for offenders who complete correctional programs.
- c. When CORI reform takes place in the upcoming legislative sessions in the Commonwealth, the issue of better displaying individual crimes be examined.

#### **XIX. Family Issues**

Addiction is a family disease and recovery is a family process. It is important for families to be both educated on the illness and supported throughout the recovery process as caring for a loved one who is struggling with an addiction is one of the most difficult situations that any individual or family will have to endure in their lifetime.

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- a. Increasing availability, access and funding to family services and peer support groups to ensure that families are given all options regarding treatment and services both for families and individuals with substance use disorder.
  - b. Increasing access to information on drug overdoses so that parents and loved ones have the lifesaving tools in the event of an emergency.

**XX. Federal Issues**

These issues are intertwined throughout many of the recommendations in this report; however, the Commission felt it necessary to include a separate section in the report on the specific issues that are beyond the purview.

- a. Federal law enforcement and regulatory programs must be involved in the policing of illegal prescription drug activity on the internet.
- b. Mental health parity must be strengthened nationally to include provisions for substance abuse coverage by insurance companies.
- c. Continuing and increasing assistance from the Massachusetts Congressional delegation in obtaining funding for vital programs in the Commonwealth.
- d. Continuing progress is necessary in regards to prescription medication monitoring through the Risk Evaluation and Mitigation Strategy (REMS) process at the Federal Drug Administration.

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## **Opioid Abuse in the Commonwealth of Massachusetts**

The rate of substance abuse in the Commonwealth is not a new topic, and the widespread abuse of opiates has increased to epidemic levels. Since the mid-1990s the widespread abuse of opiates became evident when substance abuse treatment systems in Massachusetts and several other states were inundated with opiate addicts. Addiction to the powerful painkiller, OxyContin, became evident almost immediately following FDA approval of the drug in 1995. In Massachusetts, OxyContin became so widely abused, that the addiction rate for the drug in Massachusetts increased by 950 percent over the last ten years.<sup>5</sup> The problem also became clear from the immediate rise in opioid related hospitalizations in the Commonwealth. In 2002, Boston had the highest rate of OxyContin related emergency department visits in the country and in 2005, there were more than 18,000 opioid related emergency department hospitalizations and hospital stays.<sup>6</sup>

Public and private treatment systems have been overwhelmed by the increase in those seeking treatment. Consider this startling statistic. Between 2002 and 2007 the Commonwealth lost 78 soldiers in Afghanistan and Iraq. In the same time period, 3,265 Massachusetts residents died of opiate-related overdoses. The Commonwealth is losing men and women on its streets at a rate of 42 to 1 to what the state is losing in two wars overseas. From these statistics one can see the increasing need for an in-depth look at the public policies surrounding substance abuse issues. A tremendous burden has been put on state and local governments, courts, corrections and hospitals. The state paid almost \$200 million in emergency room costs related to overdoses in 2005, the Massachusetts Department of Corrections is at 143 percent occupancy, and the Bureau of Substance Abuse Services, MassHealth and the uncompensated care pool account for more than 75 percent of the dollars spent on substance abuse services in the Commonwealth<sup>7</sup>. In fact, private insurance payments for substance abuse treatment decreased 11 percent from 1991 to 2001 while public payments increased by 68 percent.<sup>8</sup>

Addiction is a medical disorder, and we have a public health epidemic on our hands that is larger than the flu pandemic. If the H1N1 virus killed 3,000 people in a five year period in Massachusetts, the crisis would be center stage and the entire Commonwealth would be working to find a solution to protect the public. However, because of the stigma surrounding substance abuse, this epidemic is left in the shadows and little light has been put upon reforming the policies involving substance abuse in the Commonwealth.

### ***Purpose of the Commission***

The Massachusetts OxyContin and Heroin Commission (“The Commission”) was established in Chapter 302 Section 56 of the Acts of 2008 by the Massachusetts State Legislature to investigate and study the impact of the OxyContin and heroin epidemic on state and municipal government, the substance abuse treatment system and to identify potential strategies to more effectively cope with substance use disorders in the Commonwealth. The Commission is comprised of 14 members; 3 members from the State Senate; 3 members from the State House of Representatives; 1 member from the Bureau of Substance Abuse Services; 1 member from the Massachusetts District Attorneys Association; the chair of the Department of Psychiatry at the

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University of Massachusetts Medical School; 1 member from the trial court; 1 member from the Department of Correction; 1 member from the Department of Mental Health; 1 member from the Department of Community Corrections; and 1 member from the Interagency Council on Substance Abuse and Prevention.

The Commission was charged, through the enacting legislation, with examining a variety of policy issues as they pertain to substance abuse. Specifically, the Commission looked at an evaluation of the total direct and indirect cost of substance abuse to the Commonwealth; the sources of heroin, OxyContin and other prescription opiates available on the street; the number of repeat detoxifications which take place on an annual basis; the number of inmates suffering from opiate dependency; and the recidivism rates of those committed in civil commitment programs for abuse of OxyContin or heroin. Secondly, the Commission looked at policy changes in the following areas: civil commitment laws; long-term residential programs that are of at least 90 days; neurobiological impacts that affect the time an addicted individual may need to be committed for OxyContin or heroin abuse; an intensive case management system; the establishment of a system of regional secure treatment centers; statutory restrictions on parents and families with adolescents addicted to OxyContin or heroin; enhancements to the Commonwealth's prescription monitoring program; and the establishment of an outpatient commitment program.

### ***Commission Format***

From March 2009 through September 2009, the Commission held seven public hearings throughout the Commonwealth on a variety of issues pertaining to substance abuse. The hearings were held in Boston (2), Salem, Fall River, Pittsfield, Worcester, and Hyannis and each focused on a specific area of substance abuse. The Commission heard from the public and private healthcare industries, medical experts, probation and police officers, unique populations, including the elderly and veterans, treatment coordinators and many addicts, parents and family members directly affected by substance use disorders. The public hearings provided the Commission the opportunity to hear from experts from all aspects of substance abuse policy and receive public feedback on where changes can be made to policies in the Commonwealth. Throughout the hearing process the Commission came to know the many intricacies of this disease and the many pieces that contribute to solving the disease of addiction. The Commission was deeply moved by the overwhelming support that was received throughout the hearing process.

In addition to the public hearings the Commission met on several occasions to discuss various aspects of the recommendations.

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***OxyContin and Heroin Commission Meeting Schedule***

	Meeting Date	Location	Subject
<b>Meeting 1 Commission Member Informational Meeting</b>	Wednesday, March 4, 2009	State House, Room 312C Boston, MA	Introduction of Commission Members and discussion of Commission layout
<b>Meeting 2 Public Hearing</b>	Friday, March 27, 2009	Massachusetts State House Room A2 Boston, MA	Introduction of substance abuse problem in Massachusetts
<b>Meeting 3 Public Hearing</b>	Friday, April 17, 2009	Salem State College, Veteran's Hall Salem, MA	Public health system and substance abuse
<b>Meeting 4 Public Hearing</b>	Friday, May 15, 2009	University of Massachusetts, Dartmouth Advanced Technology and Manufacturing Center Fall River, MA	The courts, jail diversion, interdiction and public safety
<b>Meeting 5 Public Hearing</b>	Friday, June 5, 2009	Berkshire Community College, Room K111 Pittsfield, MA	Western Massachusetts issues, prescription monitoring program, Berkshire Health Systems Pain Management Project
<b>Meeting 6 Public Hearing</b>	Friday, June 26, 2009	University of Massachusetts Medical School, Room S1-607 Worcester, MA	Neurobiological effects of substance abuse, adolescent populations
<b>Meeting 7 Public Hearing</b>	Friday, July 10, 2009	Barnstable High School, Knight Auditorium Hyannis, MA	Unique populations; including veteran's, the elderly, co-occurring disorders
<b>Meeting 8 Public Hearing</b>	Thursday, September 10, 2009	Massachusetts State House Gardner Auditorium Boston, MA	Insurance companies stake in substance abuse issues

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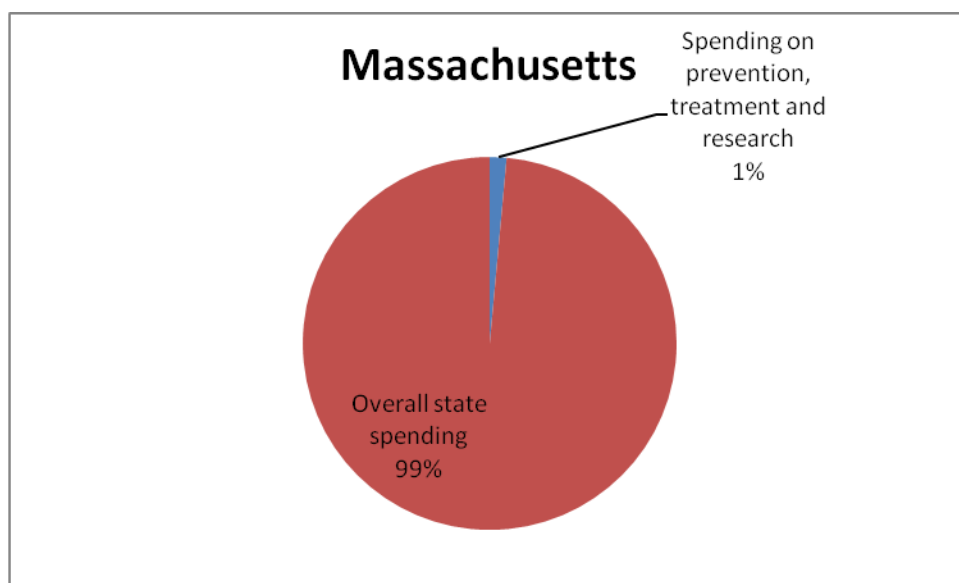
It is the Commission's hope that this report be the next step in a continuing conversation in curbing the disease of addiction in the Commonwealth. This report is not meant to be the end of the discussion, but rather the beginning of the next chapter for substance abuse policy in Massachusetts.

## Findings

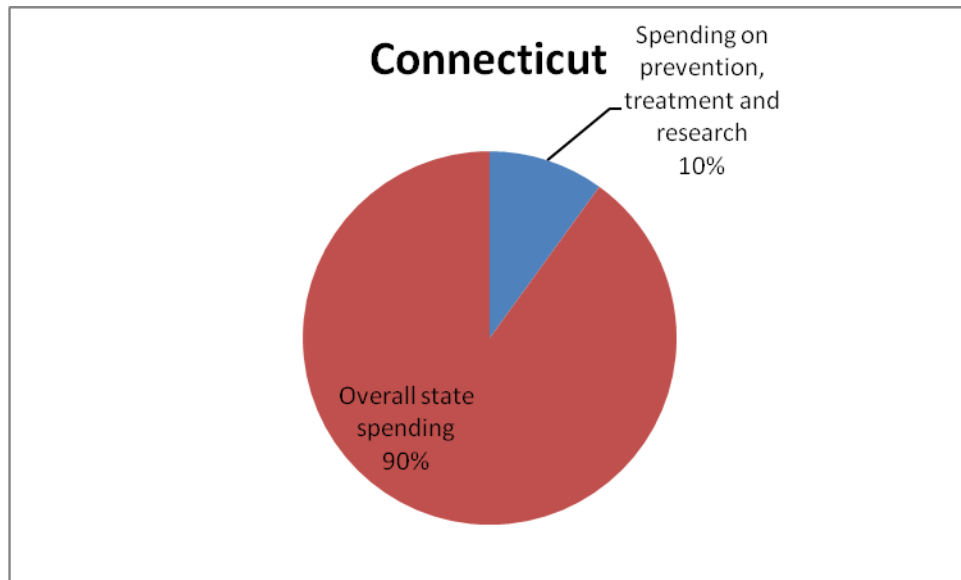
As part of the enacting legislation, the Commission was charged with finding data on a variety of issues. This included the following information: “the number of inmates suffering from opiate dependence; recidivism in the criminal justice system for OxyContin and heroin abuse” as well as “the total direct and indirect cost to the commonwealth as a result of substance abuse; the number of repeat detoxifications on an annual basis; recidivism of those committed in civil commitment programs for abuse of OxyContin or heroin.”<sup>9</sup> The following section details the findings of the Commission pursuant to the enacting legislation.

The total cost of substance abuse and addiction to the Commonwealth in 2005, the most recent year for which aggregate data is available, was over \$4.5 billion, which represented 21.8 percent of the total state budget in 2005.<sup>10</sup> Out of the over \$4.5 billion, less than 2 percent, or just over \$66 million, was spent on prevention, treatment and research outside of the money that the state is required to spend. The other 98 percent represents the cost to public programs, which includes spending on justice, education, mental health services, and public safety.

Massachusetts ranks in the lower 50 percent of states in terms of spending on prevention, treatment and research. For every \$100 the state spends on substance abuse and addiction, only \$1.45 goes towards prevention, treatment and research. By comparison, for every \$100 the state of Connecticut spends on substance abuse and addiction, over \$10 goes towards prevention, treatment and research.<sup>11</sup>



National Center on Addiction and Substance Abuse at Columbia University. *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets*. May 2009. Print.



National Center on Addiction and Substance Abuse at Columbia University. *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets*. May 2009. Print.

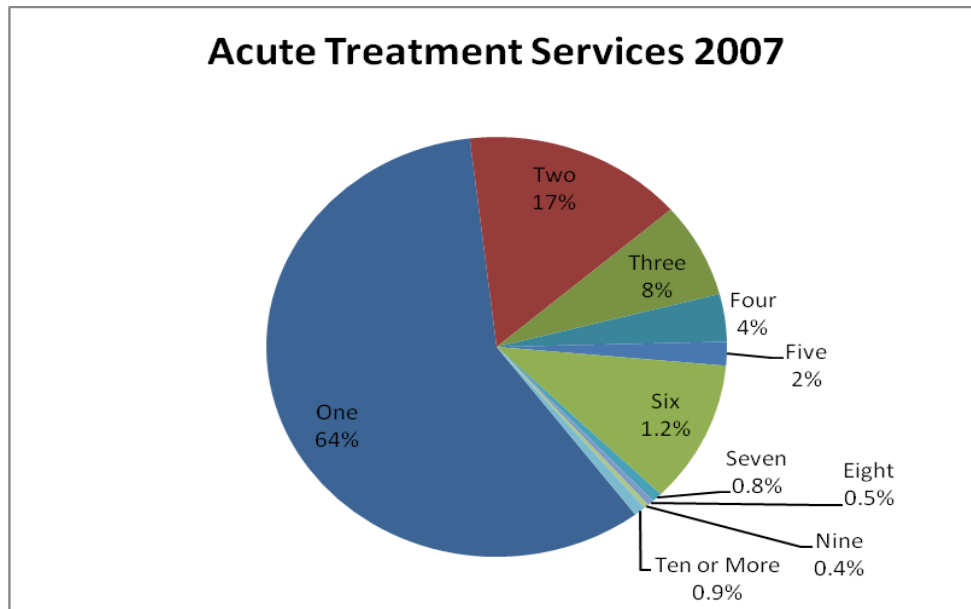
### ***Hospitalizations/Overdoses in Massachusetts***

An overdose occurs when excessive use of an opioid requires an individual to seek immediate hospitalization. In 2006, there were 23,369 alcohol and substance abuse related hospitalization discharges for non-fatal opioid-related overdoses associated with opioid abuse, dependence or poisoning. This accounted for 2.93 percent of all hospitalizations in Massachusetts that year.<sup>12</sup> The number of poisoning deaths in Massachusetts increased by 23 percent in 2006 with nearly 65 percent of poisoning deaths associated with opioids.<sup>13</sup> In 2007, 645 Massachusetts residents died from an opioid-related overdose.<sup>14</sup> This is a conservative estimate, as often times other causes of death are listed on a death certificate.

### ***Acute Treatment Services***

Acute Treatment Services (ATS) programs, also known as “detox,” are medically monitored detoxification services that provide 24-hour care under the consultation of a medical director to monitor an individual's withdrawal from alcohol and other drugs and alleviate symptoms.<sup>15</sup> In 2007, there were 18,516 individuals admitted to a state-funded ATS program for at least one ATS admission. Most of these individuals—about 64 percent—were admitted to an ATS program just once. However, 202 people entered an ATS treatment program over ten times in 2007. The burden of paying for state-funded ATS programs falls under the Bureau of Substance Abuses Services and MassHealth, with each ATS costing the state around \$1,000. Therefore, the total cost to the state from ATS programs in 2007 was over \$22 million.<sup>16</sup>

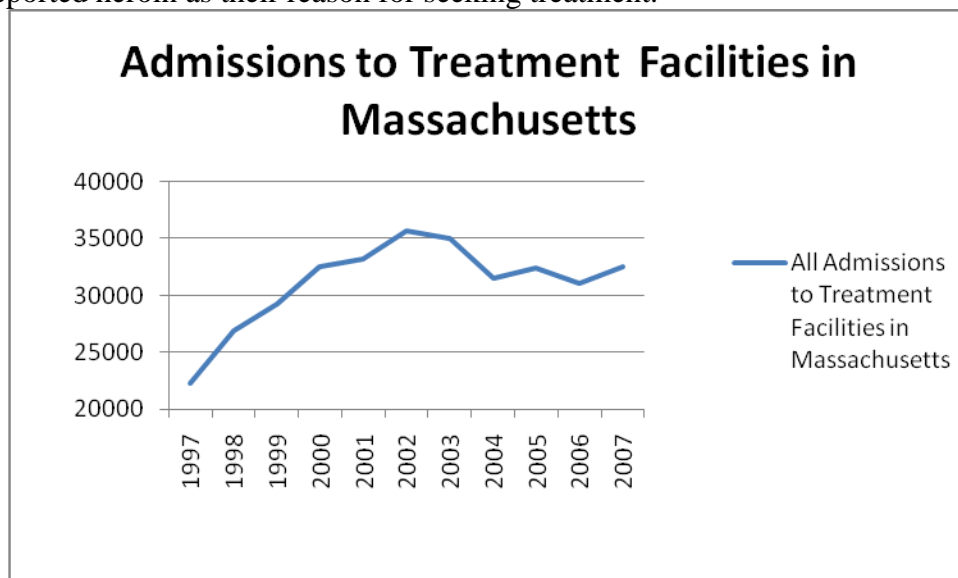




Massachusetts Department of Public Health. "Substance Abuse Services Description. n.d. Web. 12 Oct. 2009.

### ***Substance Abuse Treatment Program Admissions***

The Department of Public Health's Bureau of Substance Abuse Services keeps data on over 500 substance abuse treatment programs throughout the state, including Acute Treatment Services (ATS) and post-ATS inpatient and outpatient services. In 2007, there were 105,552 admissions to DPH-funded substance abuse programs in Massachusetts.<sup>17</sup> Of the people admitted, 39 percent reported heroin use in the year prior to admission.<sup>18</sup> Of the 41,850 hospitalized who admitted heroin use in the previous year, 85 percent also reported heroin as their primary drug and a majority reported heroin as their reason for seeking treatment.<sup>19</sup>

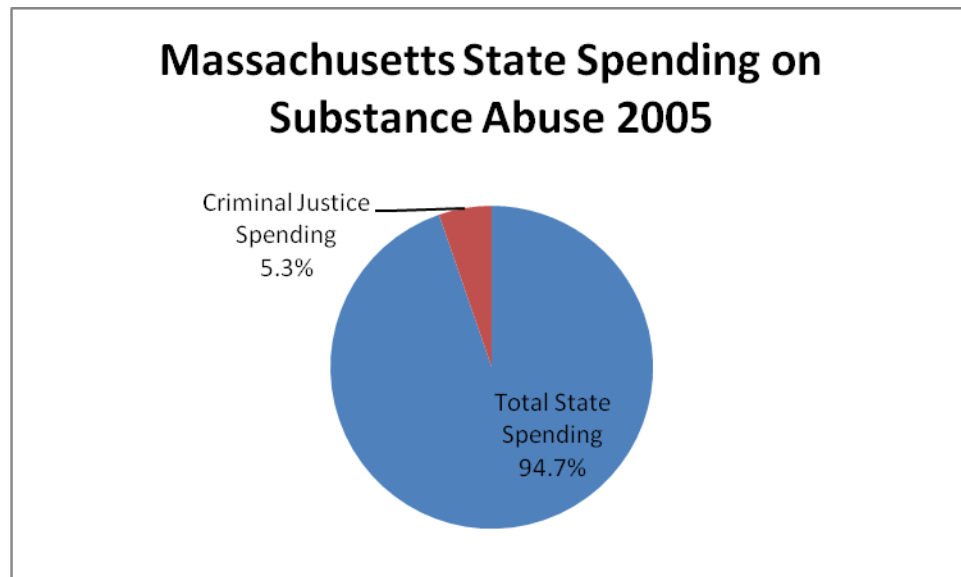


Commonwealth of Massachusetts. Department of Public Health. *Substance Abuse Treatment Fact Sheet - FY 2007 Heroin Users*. Bureau of Substance Abuse Services, 2008. Web. 25 Sept. 2009.

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## ***Criminal Justice***

The impact on the criminal justice system of the Commonwealth is demonstrated by the number of substance abusers in the corrections system, how many crimes are related to illicit opiate abuse, and the total impact on the judiciary system relating to substance abuse. These crimes burden the Department of Correction, the courts, and public safety agencies. The total amount spent on substance abuse and addiction in the justice system in 2005 was \$1.084 billion, which was 5.3 percent of the state budget.<sup>20</sup>



National Center on Addiction and Substance Abuse at Columbia University. *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets*. May 2009. Print.

## ***Corrections***

In Massachusetts today over 200,000 adults, or nearly one in twenty four, are under some kind of correctional supervision, including prison, jail, parole or probation.<sup>21</sup> Research has shown that 80 percent of offenders nationwide are either addicted to alcohol or drugs, or alcohol or drugs were involved in the commission of the crime.<sup>22</sup> Therefore, it can be established that up to 150,000 offenders in the Commonwealth have a substance abuse issue or are in correctional supervision because of their past substance abuse. The total cost to the Commonwealth on substance abuse for adult corrections in 2005 was \$810 million, over four percent of the state budget that year.<sup>23</sup>

## ***Judiciary***

The total cost to the judiciary on substance abuse and addiction was \$168 million in 2005.<sup>24</sup> The impact on the judicial system on substance abuse and addiction cases involves criminal, drug, family and juvenile courts. This includes personnel, contracted services and administration costs. Incorporated in the total cost to the judiciary are cases in which arrestees tested positive for drugs

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or reported recent drug or alcohol abuse, had previously been in a treatment program or were in need of treatment, and cases that were linked to substance abuse in other ways.<sup>25</sup>

## ***Crime***

Under Massachusetts law, heroin and other opiates are classified as Class A substances.<sup>26</sup> According to the Massachusetts Sentencing Commission's Survey of Sentencing Practices, 1,705 offenders were convicted for an offense involving a Class A substance. Out of these offenders, 771 were convicted of distributing and 934 were convicted of possessing a Class A substance.<sup>27</sup>

## ***MassHealth***

The impact of opiate abuse on MassHealth relates to the number of members who receive drug therapy, in the form of methadone or buprenorphine (Suboxone and Subutex). In addition to the cost of drug therapy, MassHealth's annual expenditures relating to opiate abuse include hospitalizations, transportation, and physician services. The following data represent total Medicaid costs, including expenditures from the Medicaid Managed Care partner organizations.

The number of MassHealth members who received any methadone or buprenorphine in fiscal year 2007 was 18,102.<sup>28</sup> The total annual expenditures for members receiving methadone and for buprenorphine was \$276.2 million and \$49 million, respectively, for a total expenditure for drug therapy of over \$325 million.<sup>29</sup> Out of the 13,951 members who received methadone in fiscal year 2007, over 40 percent (6,240) received twelve continuous months of methadone, at a cost of over \$91 million.<sup>30</sup> The average cost per member for methadone was \$19,799 and for buprenorphine was \$11,820.<sup>31</sup>

## ***Municipalities – City of Boston***

As the largest municipality in the Commonwealth, the City of Boston serves as an excellent illustration of how the substance abuse epidemic impacts the services and budgets of large cities. The large population of Boston provides a data set that enables the Commission to gauge the impact of substance abuse on a densely populated city. Furthermore, in recent years Boston has been one of the Commonwealth's epicenters of illicit OxyContin and heroin abuse. This increase correlates to a spike in hospitalization and mortality rates. From 1999-2007 the mortality rate surrounding substance abuse increased 77.3 percent.<sup>32</sup>

The Drug Unit of the Boston Police Department (BPD) tracks of the number of samples of illegal controlled substances that are obtained by officers through arrests and controlled buys. These samples are submitted to a laboratory that determines the type of substance. The number of heroin seizures made by the BPD in 2008 was 1,099 and the number of OxyCodone seizures was 247.<sup>33</sup>

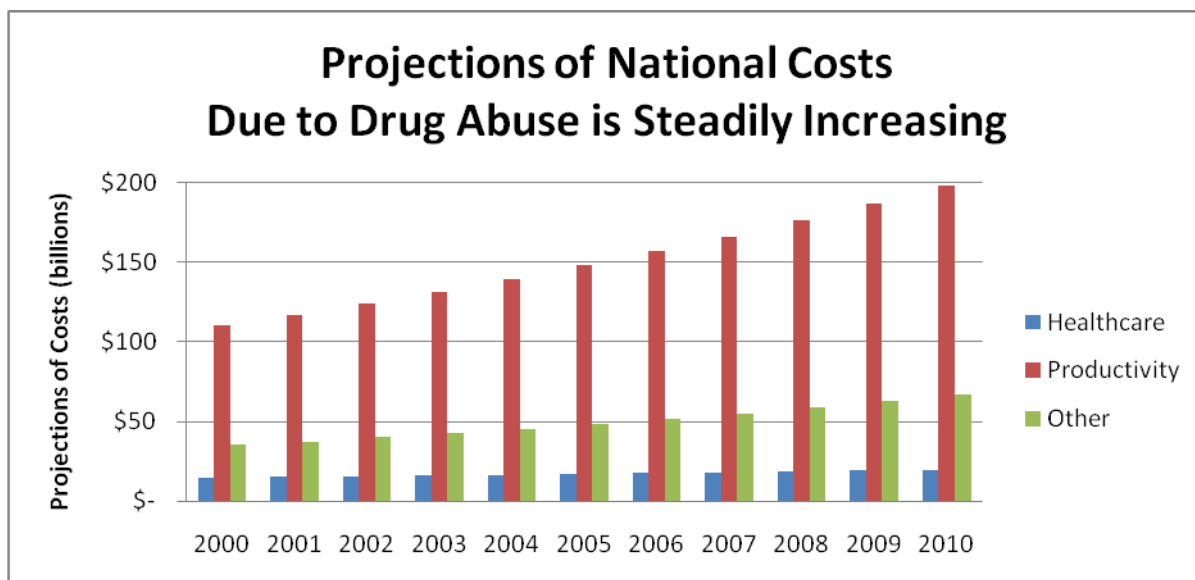
Opiate abuse also has a significant effect in the daily work of Boston's Emergency Medical Services (EMS). The cost transporting of a patient to a hospital is difficult to quantify given the level of service needed, either basic life support or advanced life support, and the possibility that

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two units respond to the same incident. In 2008, Boston EMS personnel spent over 140 hours responding to heroin-related incidents, with 117 basic life support responses and 86 advanced life support responses.<sup>34</sup> The total charge for the basic and advanced responses are \$935 and \$1,870 respectively, so the total cost to the city on EMS relating to heroin in 2008 was \$270,215.<sup>35</sup>

### **State Workforce**

While not originally required from the enacting language, this data contribute to a more comprehensive understanding of substance abuse and addiction in Massachusetts. Substance abuse and addiction have a significant negative impact on the state's workforce. Employees with drug or alcohol problems are more likely to miss work, be involved in workplace accidents, file workers' compensation claims, and are 33 percent less productive than their non-abusing coworkers. Nationally, it is estimated that productivity loss due to substance abuse was close to \$15 billion in 2000.<sup>36</sup> In 2005, it is estimated that the Commonwealth spent \$21.37 million on state workforce costs relating to substance abuse and addiction.<sup>37</sup>



National Center on Addiction and Substance Abuse at Columbia University. *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets*. May 2009. Print.

### **Recommendations**

The following section outlines the twenty issue areas for which the Commission recommends policy changes. Throughout the public hearing process these core issue areas were brought up on numerous occasions and therefore represent the most important areas for policy change. The Commission feels that by utilizing multiple aspects of these solutions the most effective outcomes can be achieved.

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## ***Regulations***

A variety of changes in regulations have been proposed to improve the services the state provides and give better insight to various under-monitored areas of substance abuse regulation. It is the hope of the Commission that through the Commonwealth's regulatory process many policy changes can occur in a manner that enables state agencies the greatest flexibility and control. These regulatory changes include improving the prescription monitoring program (PMP), which entails expanding the schedule medications that are monitored and allowing physicians and law enforcement to access the valuable information that the PMP can provide; requiring those administering prescriptions which may include prescription opioids to use tamper-resistant prescription pads, ensuring that doctors can more safely administer medications and save the Commonwealth millions of dollars in prescription fraud; require pain management training for all doctors, nurses, physician's assistants and dentists; preventing overdose deaths with limited liability legislation and requiring that should a minor overdose and be taken to a hospital, that their parents be informed of the overdose and provided with information about seeking treatment.

### **Massachusetts Prescription Monitoring Program**

A consistent theme at the Commission's hearings was the failure of the Massachusetts Prescription Monitoring Program (PMP) to be an effective resource to combat the opiate epidemic. The opiate crisis in Massachusetts is largely fueled by the misuse of prescription medication; to this end the Commission analyzed the variety of ways that legally manufactured pharmaceuticals end up being used for illegitimate purposes. In almost every case of the ways which these medications reach the street, the PMP could have acted as a preventative measure.

One of the most apparent uses of the PMP as a resource to cut off access to these dangerous prescription opiates is ending the deceptive practice of "doctor shopping" by addicts. Doctor shopping, or pharmacy shopping, is a common practice among those addicted to opiates; whereby drug seeking individuals target doctors who are known to be busy or sympathetic, or visit multiple doctors and pharmacies until the addict has the desired prescription filled. Doctor Carol Bates, Primary Care Program Director at Beth Israel Deaconess Medical Center, said in testimony regarding updates to the PMP:

"There is a strong sense across teaching institutions that we see a flood of drug seeking patients - particularly in July when new interns arrive in training. Drug seekers are knowledgeable about the healthcare system and often target those with the least experience... Programs in other states with complete registry information have been highly effective. As I understand it, there have been no examples of breach of confidentiality or inappropriate access to systems in those states that have complete registry provider access."<sup>38</sup>

While it is impossible to completely end the misuse of prescription medication, drastically reducing the flow of these drugs so that they are not as prevalent in communities across the Commonwealth is an attainable goal. One of the most efficient ways at the state level to stop

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fraud, and reduce the availability of dangerous prescription drugs on the street, is an active and useful PMP. For the past decade while Massachusetts has been faced with a prescription drug crisis, at the same time, our PMP system has fallen behind other states. The lack of attention to its status, and utilization of this program, has further enabled this epidemic to flourish unchecked. For these reasons, the resuscitation of the PMP is one of the most promising recommendations of this Commission and we believe its proper administration will be a tremendous asset going forward.

The state's inability to use this system to intervene in clear cases of prescription drug abuse, to reduce the frequency of "doctor shopping" or use data from this program to target resources is, perhaps, one of the greater tragedies in this decade long struggle with opiate abuse. The lack of dedicated resources to the Commonwealth's PMP continued across several administrations and, as a result, cost the state hundreds of millions of dollars. The PMP is funded in part by the Massachusetts Drug Control Program and by federal grants and is assigned one half of a full-time employee for its administration.

Through several administrations the program lacked staffing and was ignored as fraudulent prescriptions and prescription overdose death rose at alarming rates. In addition to being a preventative tool for public health officials, the PMP presents an opportunity for the state to prevent Medicaid fraud and keep close track of its spending on this class of pharmaceuticals, on which Massachusetts spends millions of dollars each year.

#### *Background on Prescriptions Drug Monitoring Program (PDMP)*

A Prescriptions Drug Monitoring Program (PDMP) is an electronic database managed by the state to collect data on substances prescribed within the state. The database management and reporting structure is housed in a specific state agency, generally a law enforcement or public health agency. The responsible agency will send notifications, reports and information to specific groups or individuals authorized by the state to receive this information. This data may be relayed to a patient, medical practice, or law enforcement agency.

According to a report by the National Alliance for Model State Drug Laws (NAMSDL) a PDMP may serve multiple purposes, including:

- To support access to legitimate medical use of controlled substances.
- To help identify and deter or prevent drug abuse and diversion.
- To facilitate and encourage the identification, intervention with and treatment of persons addicted to prescription drugs.
- To help inform public health initiatives through outlining of use and abuse trends.
- To help educate individuals about PDMPs and the use, abuse and diversion of an addiction to prescription drugs.<sup>39</sup>

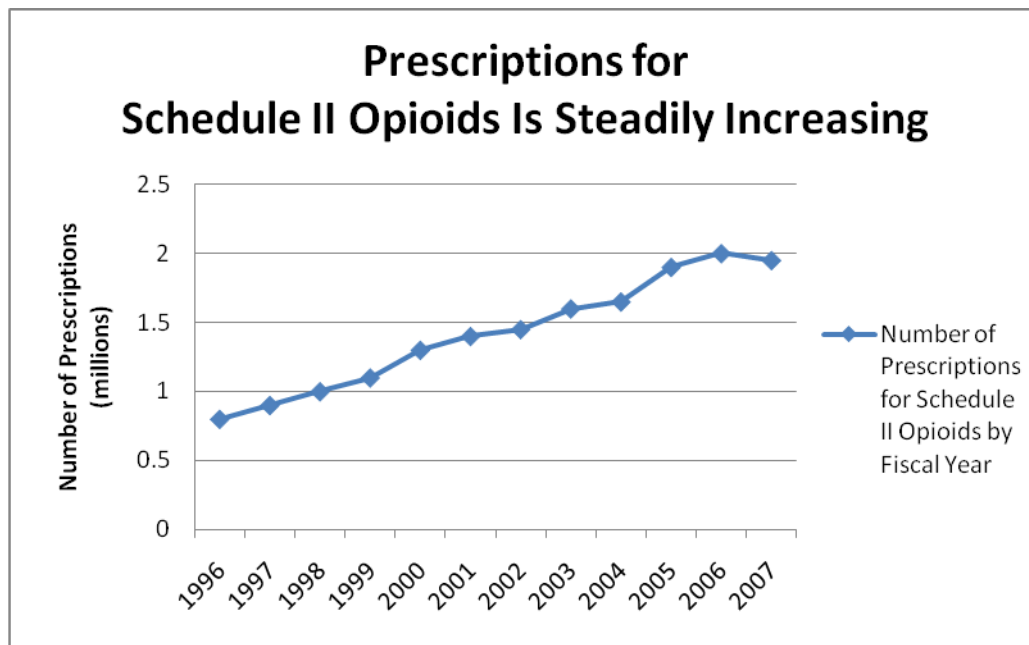
The Massachusetts Prescription Monitoring Program (PMP) was developed in 1992 through a joint regulation of the Massachusetts Department of Public Health (DPH) Drug Control Program (DCP) and the Massachusetts Board of Registration in Pharmacy (Board) with funding from a

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federal grant.<sup>40</sup> The program uses a computer-based, electronic data transfer (EDT) system to collect prescription data. Medical Review Groups (MRG's) comprised of practitioners and pharmacists provide peer review of the medical data and assist the Drug Control Program in reviewing data for release to law enforcement and regulatory agencies.

The Massachusetts Prescriptions Drug Monitoring Program was developed in 1992 through The Mass PMP receives data on all Schedule II controlled substances dispensed by Massachusetts community pharmacies and Massachusetts registered hospital outpatient and clinic pharmacies. Information is sent through an electronic data transmission (EDT) through a third party vendor, Atlantic Associates Inc. The information is analyzed by the Department to look for prescribing and dispensing trends, and to provide case information to regulatory and law enforcement agencies concerning drug distribution and potential diversion.<sup>41</sup>

In FY2008 3.3 million Schedule II prescriptions were monitored by the Massachusetts PMP.<sup>42</sup> Reports are provided to authorized end users (regulatory boards, state and federal law enforcement); however they are not available for prescribers or pharmacies to research their client base. Some of the types of diversion cases reviewed by Massachusetts PMP include illicit prescribing, doctor shopping, forgery and pharmacy diversion. Additionally, pharmacies and registered health care facilities are required to submit a monthly report to Atlantic Associates.<sup>43</sup>



Massachusetts Department of Public Health (MDPH). Drug Control Program. *Prescription Monitoring Program (PMP) Handbook for the Pharmacist and Pharmacy Software Provider*. 16 Sept. 2008. Print.

This reporting structure means that the information being used to analyze reports is 3-4 weeks old, limiting the ability for law enforcement agencies investigate potential illegal behavior. The most egregious failures of the Commonwealth's PMP may well be Dr. Michael Brown, a Cape Cod Doctor who practiced in Sandwich. According to evidence presented to the Board of Registration in Medicine, Dr. Brown was the single leading prescriber of OxyContin in the entire

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state, with his prescriptions accounting for 288,859 of the 922,985 OxyContin tablets filled through pharmacies in 2004. If the PMP was operating as an active bureau processing incoming data in real-time, an analyst working at the PMP would have immediately recognized this disproportionate trend and provided notices to law enforcement.

The Prescription Monitoring Program's records show that Brown, an internist working alone in Sandwich, prescribed about 1.7 percent of the OxyContin prescribed in the state in 2004. The 144,435 tablets of the narcotic he prescribed in the first six months of this year led the state's doctors by a wide margin. Although monitors collect information on more than 2 million prescriptions for potentially addictive drugs each year, they rarely release information about individual doctors unless police or regulators request it – and then only if a panel of doctors and pharmacists agrees that release of information will not unfairly raise suspicions. Dr. Brown's case highlights the gap in the prescription drug monitoring system.<sup>44</sup>

One of the most compelling stories the Commission heard was a mother from Pittsfield who testified about her daughter's struggle with prescription drugs after being legitimately prescribed painkillers. Her story is a prime example of both the nature of this disease, and the failures of the prescription monitoring system. In several instances, the daughter went to multiple pharmacies and doctors that prescribed her opiates, each doctor and pharmacy not knowing she was receiving prescriptions from multiple sources. In this case the PMP should have been a preventative tool, to both stop the fraudulent prescriptions and call her addiction and multiple prescriptions to the attention of her health care providers. Unfortunately, the young woman is no longer with us.

### *Comparison Programs*

Two examples of progressive, gold standard PMP programs exist in the Kentucky and Connecticut models. These programs provide real-time, online access to their data for several groups of stakeholders, and have demonstrated their ability to effectively monitor and intervene with illegal prescription drug use.

Kentucky, similarly impacted by a prescription drug epidemic, created Kentucky All Schedule Prescription Electronic Reporting (KASPER) in 1999. KASPER is a PMP that has set a high standard for effectiveness. While Kentucky is able to collect and update data from prescription monitoring every 8 days, the Massachusetts PMP updates data once a month. The Kentucky program has some 5,500 requests for reports every month while Massachusetts averages 10 requests per month. Of the requests in Kentucky, 92 percent are from prescribers, as compared to Massachusetts where 61 percent of requests come from law enforcement and 30 percent from licensing boards.<sup>45</sup>

The Kentucky program can provide doctors and police agencies with information on suspected prescription-drug abusers within 24 hours.<sup>46</sup> Kentucky's program, which is being used as a model for other states, has been successful because it includes privacy protections and tracks all scheduled prescriptions that can be addictive or misused. The effectiveness of this program can be seen in the ability for several stakeholders to use the data immediately in order to limit the ability for people to mis-prescribe, or to abuse the prescription medication.



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Kentucky has implemented KASPER trend data reporting and analysis to produce Geographic Information System (GIS) maps identifying controlled substance usage along with increases and decreases over time by geographic area. These reports are intended to provide a tool for the licensure boards and law enforcement to identify where they need to focus investigative resources. The trend reports will also provide a tool to increase the awareness of health care providers about potential problems with controlled substances in selected geographic areas.

Similar to the Kentucky program the Connecticut PMP, which went into effect on 2008, requires pharmacies to submit their orders for all Schedule II – V prescriptions. The Connecticut PMP is a web-based application that allows prescribers and pharmacists to access a patient's prescription information online. As a safety measure these licensed healthcare professionals must register for access to the database by supplying the PMP with the appropriate credentials prior to receiving any patient information.<sup>47</sup> The website is accessible 24/7, and in many cases a patient report can be viewed in a matter of seconds. The report data is based on information submitted by the dispensing pharmacy. The information in a report can alert a physician or a law enforcement group to the number/times a prescription has been filled for a patient, as well as who prescribed the prescription. This real-time information allows for physicians and law enforcement agencies to monitor, and quickly react to the individual abuse of prescription drugs. Effective management and monitoring of this information can limit the amount of narcotics in the market, as well as limit access points for illegally obtaining the drugs.

Many states would like to see the integration of a national program, which would create a standard model for reporting, and use of this data. The success that states are having with the tracking systems has led advocates to push for a national system that would link together the states' databases. A national program would deter individuals from crossing state lines to fill prescriptions in other states.

The Commission recommends that the Massachusetts Prescription Monitoring Program be overhauled so that it is a useful resource for the many state agencies, and non-governmental entities that have a stake in the careful monitoring of pharmaceutical distribution. This system must be a real-time database; prescribers should have the most information at their disposal when making decisions relevant to pain management. Law enforcement and state accounting agencies should have access to these records to detect patterns of fraud and illegal activity. Public health officials must be able to use this data to target state resources to combat startling rates of addiction.

If the technology must be updated for this to occur, it would be money that would almost be immediately recouped by the state in savings. New York, after implementing an active PMP in conjunction with serial prescription pads, realized a 500 percent savings in their health care accounts. While improvements in the ability to access this data is important, the role of the PMP must be redefined.

A culture change and redefinition of the role of the PMP is necessary to make this a worthwhile program. The structure of how the information gathered by the PMP is disseminated appears to be one of the primary obstacles for. While ideally this program should be housed at the

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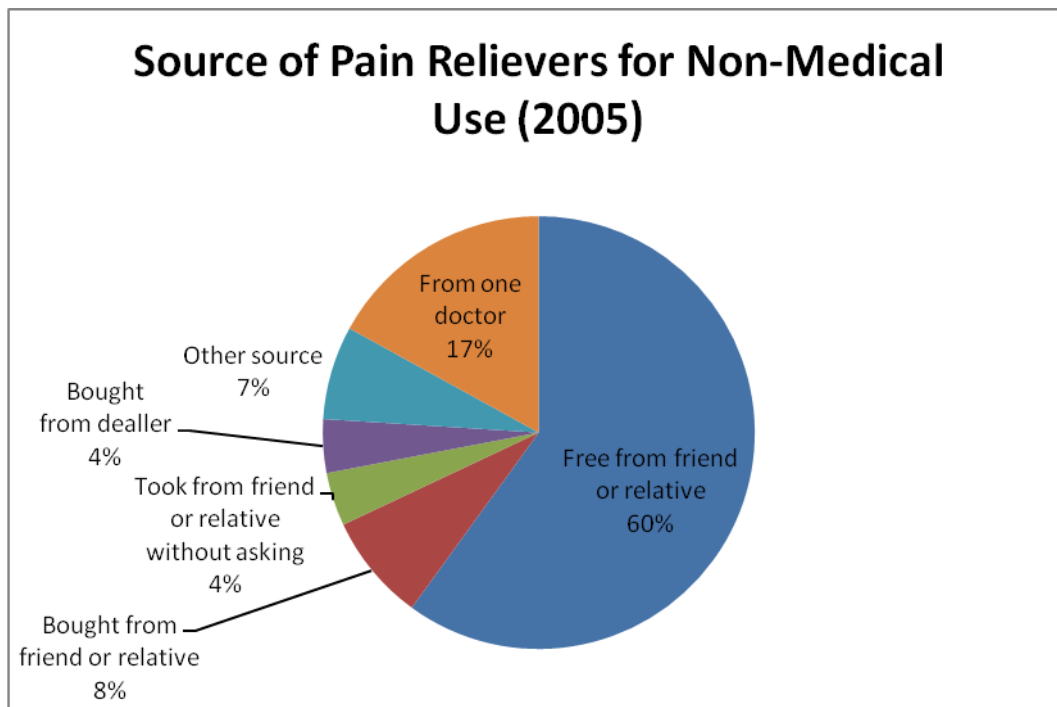
Department of Public Health, many other states run their PMPs out of the Board of Pharmacy, or in the Attorney General or Inspector General's offices. The structure of how the data is processed should also be re-evaluated; the current system is entirely too restrictive and does not provide any entity, aside from the medical review group, with the requisite information.

The flow of information must be streamlined, and the current bottlenecks in the system must be removed. Staffing this system must also be made a priority by the Department of Public Health. Currently, the PMP acts as a repository for information with few examples of usefully investigatory or analytical activity. For the PMP to be a useful tool for the Commonwealth, the PMP must be more than that, changes need to be made so that the PMP actively provides information to the many entities that find this data critical.

The reinvention of the PMP represents an opportunity for this state to make a practical and immediate change for the better. A substantive reform of the Massachusetts Prescription Monitoring Program is one of this Commission's highest priority recommendations for immediate action that has the ability to make a worthwhile impact on the opiate epidemic.

### **Pain Management Training and Education**

Studies show that nationally, fewer than 40 percent of physicians receive any type of pain management training in medical school.<sup>48</sup> This includes training in identifying prescription drug abuse, proper prescribing methods and drug diversion. According to Dr. Nathaniel Katz, Director of Program on Opioids Risk Managements at Tufts University School of Medicine, "many specific prescription opioid fatal overdoses and cases of addiction are linked to prescribing errors, primarily prescribing to patients at high risk of abuse and addiction, and failure to monitor for adverse outcomes." According to national data from the National Survey of Drug Use and Health (NSDUH), 17 percent of individuals abusing prescription drugs received them from one doctor. This is more than those who bought the drug off a friend or relative, stole the drug from a friend or relative and bought the drug from a dealer combined.



Substance Abuse and Mental Health Services Administration. Results from the 2005 National Survey on Drug Use and Health: National Findings. Office of Applied Studies, NSDUH Series H-30, DHHS Publication No. SMA 06-4194. Rockville, MD. Web. 22 Oct. 2009.

The Commission believes that educating our doctors, dentists, physician's assistants, nurses and pharmacists is a major tool in fighting the legal prescription drug abuse trade. Given the increased need for pain management and abuse training, the Commission recognizes three areas of improvement for the Commonwealth.

1. Continued support of the use and development of evidence-based educational materials for teachers, law enforcement and other health professionals.
2. Improved training on the identification and intervention of prescription and illicit drug abuse.
3. Improved pharmacy training on the identification of prescription drug abuse and the security measures necessary to deter such abuse.

*Continued support of the use and development of evidence-based educational materials for teachers, law enforcement and other health professionals.*

The Bureau of Substance Abuse Services has developed a pocket-sized guide for clinicians, "Opioid Analgesics and Stimulant Medications: A Clinician Guide to Prevent Misuse." It contains screening tools for adults and adolescents, points for prescribing medications and counseling patients, and further clinical resources. It has been sent to physicians across the Commonwealth. Over 3,000 of these guides have been distributed, primarily to prescribers of these medicines. The Commission recommends that the Bureau prepare an updated guide for re-distribution. These materials should address substance abuse prevention, the warning signs of

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drug abuse and methods of intervention and identification of treatment resources available to consumers across the Commonwealth.

*Improved training on the identification and intervention of prescription and illicit drug abuse.*

The Commonwealth should take steps to ensure that Massachusetts physicians who prescribe narcotic medications receive substantive training in: 1) effective pain management, 2) identification of patients at high risk for substance abuse, and 3) other aspects of drug abuse. DPH and the Board of Registration in Medicine should work closely together to further develop effective strategies to ensure that physicians are properly and effectively trained.

Clinician training should be targeted to individuals with identified needs to ensure the most effective, focused and meaningful programs as well as the most efficient use of resources. The professional Boards of Registration (e.g., Medicine, Dentistry, Podiatry, Veterinary Medicine, Nursing and Physician Assistants) have the authority as well as the infrastructure and expertise to oversee clinical practice issues, including training requirements. The Commission recommends that the Department of Public Health (DPH) work through the Prescription Monitoring Program Advisory Council, which includes the professional Boards of Registration, to identify ways to improve information sharing and coordination that will assist the Boards in targeting programs to improve clinical skills assessment, pain management, drug diversion, and abuse. In 2004, the Board of Registration in Medicine adopted the Federation of State Medical Boards' Model Policy for the Use of Controlled Substances for the Treatment of Pain, which is a communication to physicians on the best practices for safely prescribing pain medications. Continuing education courses are presented many times each year at various locations throughout the Commonwealth. Moreover, DPH has proposed regulations to authorize providing clinicians with prescription monitoring information to help them identify their patients' potential diversion or harmful use of Schedule II pain medications through an online prescription monitoring data system. DPH is developing guidelines to help clinicians reduce opportunities for drug diversion and increase prevention of and facilitate intervention in drug addiction and abuse.

At present there is no mechanism to mandate prescriber training as a condition of obtaining a Drug Enforcement Administration (DEA) Controlled Substance Registration Certificate. Similarly, by current statute the Massachusetts Controlled Substances Practitioner Registration issued by DPH provides no basis to mandate prescriber training. While the Massachusetts professional Boards of Registration mandate continuing education as a basis for licensure, the Boards do not require specific training in this area, and are reluctant to embark on a precedent of mandating focal training for all practitioners. Any new mandate for training would likely require legislative action in the form of a statute or regulation.

The Commission also recommends that opportunities for encouraging voluntary prescriber education should also be pursued. For example, collaboration between the professional Boards of Registration, the Department of Public Health and the University of Massachusetts Medical School could result in a web-based training curriculum for physicians and dentists which could provide free risk management Continuing Medical Education. Such a resource, if well-designed

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and publicized, could result in a significant number of prescribers receiving targeted training in the absence of any mandate for a relatively modest appropriation.

*Improved pharmacy training on the identification of prescription drug abuse and the security measures necessary to deter such abuse.*

The Board of Registration in Pharmacy should consider developing a required course as an integral part of the continuing education requirements for pharmacists who store, distribute and dispose of drugs subject to abuse. Both pharmacies and pharmacists licensed by the Board of Registration in Pharmacy (the Board) are mandated to maintain strict security controls of all prescription medications ordered, received and dispensed, in accordance with deferral and state statutory and regulatory requirements. The Board provides training to pharmacists regarding security requirements as part of the continuing education course curriculum present on multiple dates and at various locations throughout the Commonwealth each year. Pharmacists complete coursework in these areas as part of the school of pharmacy curriculum. To qualify for licensure as a pharmacist in the Commonwealth, individuals must successfully complete the Multistate Pharmacy Jurisprudence Examination that includes federal and Massachusetts laws and regulations on the topics. The Commission recommends that the Board revise 247 CMR sections pertaining to the Prescription Monitoring Program (PMP) that apply to the dispensing of controlled substances by pharmacists when the revisions currently proposed to the PMP regulations are promulgated to reduce opportunities for drug diversion and facilitate intervention. In addition, the Drug Control Program (DCP), in cooperation with the Board, will develop training programs and materials for pharmacists to implement the proposed amendments. The training will include guidance on utilization of PMP information to assist patients with potential Schedule II pain medication problems and facilitate prevention of and interventions with drug addiction and abuse. The DCP will also cooperate with the Board on the development of information on dispensing, storage and disposal of controlled substances to reduce opportunities for drug diversion.

### **Tamper-Resistant Prescription Pads**

Currently in Massachusetts, there are far too many ways for individuals who have not lawfully been prescribed OxyContin to obtain it. An individual could unlawfully obtain the drug, buy it on the street, or obtain a prescription for the drug by presenting a fraudulent prescription at a pharmacy. Fraudulent prescriptions have become a growing problem in the Commonwealth since the advent of OxyContin and other strong prescription pain medications.

Three basic categories of false prescriptions exist. The first is writing a fraudulent prescription on a legitimate prescription pad—an individual might steal a doctor's prescription pad and then, at a later time, write a prescription. The second is writing a forged prescription on a counterfeit prescription pad—an individual might copy a legitimate prescription written for them by a doctor and manipulate it in such a way to create a forged prescription pad on which they are then able to write counterfeit prescriptions. Lastly, is altering a legitimate prescription to increase the quantity, dosage or to add an additional drug.<sup>49 50 51</sup>

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It should be made clear that falsified prescriptions are not solely related to abuse from OxyContin. Instead, the issue of fraudulent prescriptions is one that affects all drugs which have off-label uses (illegal and otherwise). The issue then is how the Commonwealth can eliminate the ability of people to obtain drugs and therapies without legitimate medical need.<sup>52</sup>

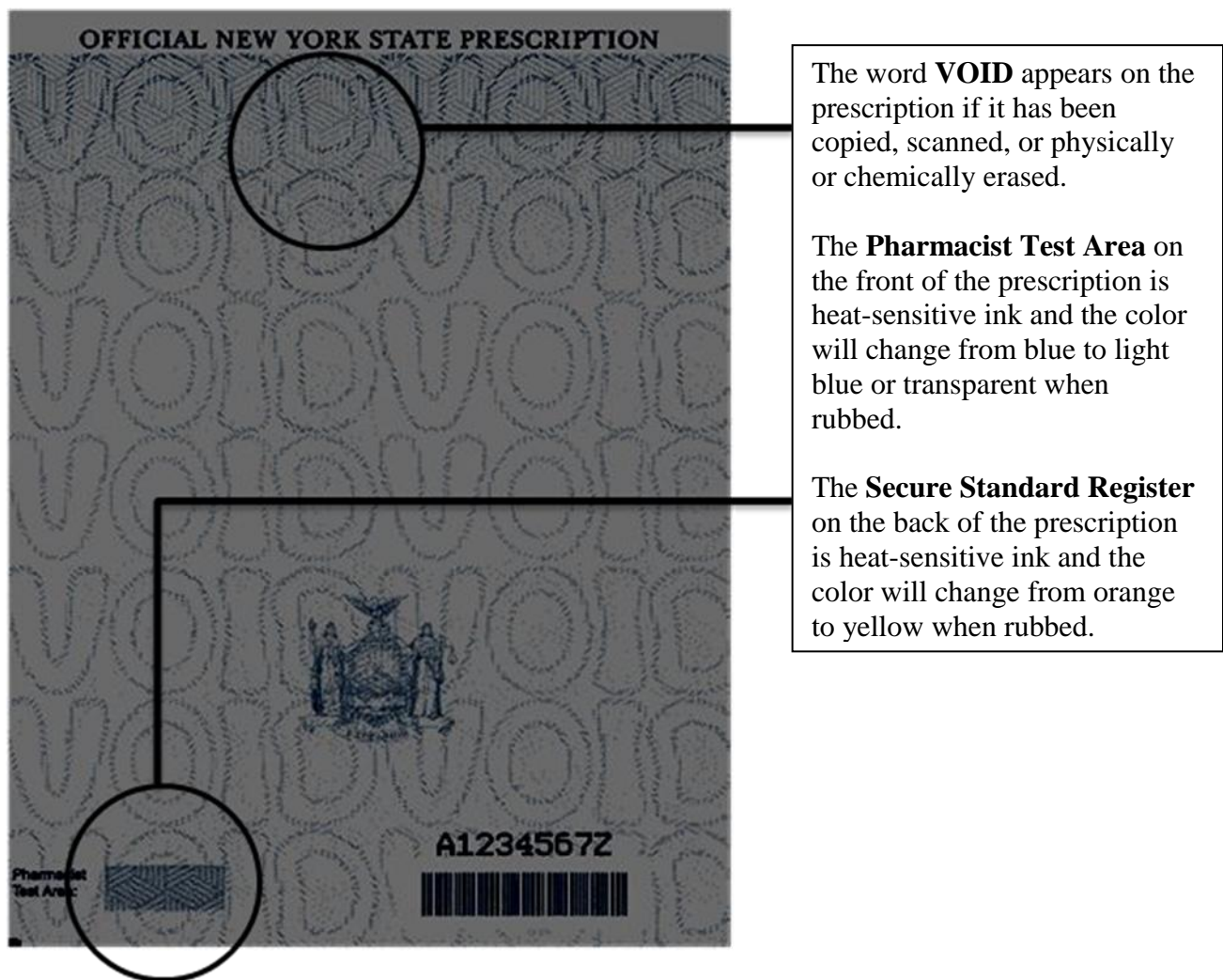
One solution to eliminating the number of fraudulent prescriptions is inexpensive and would not require a complete redesign of the current prescription drug delivery system. The creation of a tamper-resistant prescription pad program would allow Massachusetts to take action toward limiting the abuse of all three types of prescription fraud without having to eliminate written prescriptions and move toward a web-based prescription program. The Commission believes that the implementation of such a program has the ability to dramatically cut the number of fraudulent prescriptions that are filled in the Commonwealth each year.

Many states such as New York have implemented such programs and are seeing great success. Additionally, tamper-resistant prescription pads are already required by the federal government in order for Medicaid to reimburse patients and states for the cost of prescription drugs. Starting on October 1, 2008 all written, non-electronic prescriptions were required to contain at least three tamper-resistant features, one from each of the three baseline characteristics outlined by the Centers for Medicare & Medicaid Services, in order for Medicaid to reimburse.

A “regular” prescription pad may include the name of the doctor’s practice; the doctor’s address and telephone number; the name of the patient to whom the drug or therapy is being prescribed; the date the prescription was written; perhaps the address of the patients; whether the prescription maybe refilled (and how many times); and, space is also provided for the prescribing medical professional to write the name and dosage of the drug being prescribed and to sign the prescription. These pads are not regulated, except in the case of Medicaid prescriptions and a doctor may print them him/herself. A tamper-resistant prescription pad, on the other hand, is essentially the same as a “regular” prescription pad save the paper that has been used to produce the pad itself and the addition of several security features. First, instead of being normal copy paper the tamper resistant pad has been made of special paper which is resistant to erasures and alterations. This means that a prescription cannot be amended to increase the dosage or to increase the number of renewals available to the patients. Additionally, a tamper-resistant prescription pad is also printed in such a way that an individual is unable to photocopy the prescription for duplication. This is done much in the same way that bank checks are protected against photocopied reproductions. Finally, a tamper-resistant prescription pad has a security back print.<sup>53 54 55 56 57</sup>

As stated above, New York recently adopted a tamper-resistant prescription pad program. The New York program requires that all prescriptions for controlled substances be written on official New York State prescription pads, which contain tamper-resistant features, and that no exemptions to this rule may exist. Additionally, under the New York State program prescriptions for non-controlled substances must also adhere to strict requirements. In order to be accepted a prescription for a non-controlled drug must either be written on an official New York State pad, or it must be written on a facility’s own prescription pad with a facility label affixed to it.<sup>58</sup> A facility label is a label on which a bar code has been printed that contains facility specific information readable by a computer. In addition, a facility label also contains

safeguard which protect against the production of fraudulent labels in order to authenticate an illegitimate prescription.<sup>59</sup> For example, an authentic facility label in New York State contains a light blue pharmacist test area on the right side of the label, slight perforations along all sides of the label which prevent the label from being easily removed once it has been affixed to a prescription, and the labels are individually serialized in the same way as official prescriptions. A New York style program would benefit Massachusetts greatly by minimizing the illegitimate prescriptions and standardizing the prescription pad system in the Commonwealth.



New York State. Department of Health. Bureau of Narcotic Enforcement; *Pharmacy Update*, Winter 2008. Web. 19 Oct. 2009.

Implementing a tamper-resistant prescription pad program would allow additional safeguards to be built into the prescription delivery system without incurring major additional expense or creating a major disruption to the system while significantly limiting prescription fraud and saving the Commonwealth millions of dollars in counterfeit prescription costs. A sound policy such as this would provide Massachusetts with yet another tool to combat prescription drug abuse and curb this dangerous epidemic.

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## **Preventing Overdose Deaths with Limited Liability Legislation**

From 1990 to 2006, the Massachusetts age-adjusted poison death rate more than doubled from 5.6 to 14.9 per 100,000 residents. Almost 65 percent of Massachusetts' poisoning deaths in 2006 were caused by opiate overdoses.<sup>60</sup> Many of these deaths could have been prevented if the opioid abuser had received proper emergency medical services. Research shows that only 15 percent of fatal overdoses result in instant death, meaning that many lives could be saved if people who overdose receive prompt medical attention.<sup>61</sup>

The fear of arrest and prosecution often keeps opioid abusers from calling authorities when a friend or family member overdoses. Recent studies indicate that over half of the drug users interviewed did not call 911 during an overdose for fear that the police would prosecute them for illegally using drugs.<sup>62</sup> Many of these deaths could be avoided if Good Samaritan legislation were enacted in the Commonwealth. A Good Samaritan law would provide limited immunity from drug possession charges and prosecution when a drug-related overdose witness or victim calls for medical attention. The law would not however, protect people from prosecution from offenses other than possession of illegal drugs when calling 911, nor would it protect individuals with outstanding warrants against them or those who interfere with law enforcement procedures to secure crime scenes.

New Mexico was the first state to enact limited immunity legislation in 2007 and has seen very positive results. Several other states – Connecticut, Hawaii, Illinois, Nebraska, New York, Rhode Island – are considering similar bills. Many colleges and universities around the country have also led the way on this issue by including limited liability policies for their student population. Currently, at least 91 schools in the country have implemented a Good Samaritan policy for alcohol or drug abuse.<sup>63</sup> A recent study showed that after Cornell University implemented a medical amnesty protocol, calls for emergency medical services for alcohol-related incidents increased.<sup>64</sup>

The Commission recommends that the Commonwealth enact a sensible limited liability law similar to New Mexico's that will be effective in decreasing the number of overdose deaths. The Commission also recognizes the need to include language that will ensure that offenders will not be able to exploit the law to evade prosecution and that it will only apply to potentially fatal situations. The implementation of this law will also require a significant effort to educate the public on the components of the law. Educating the public on these laws will enable the Commonwealth to prevent many senseless and preventable overdose deaths.

## **Overdose Prevention for Minors**

The Commission believes that parents should be given the right to know when their child has an overdose. Many parents told the Commission that when their child experienced an overdose and was taken to the hospital they were never notified. Under current statutes and regulations, minors can check themselves out of the hospital and a parent may never be informed. This has obvious consequences for both the minor and parent and leads to a complete breakdown in communication. Currently, if a minor is caught under the influence of drugs or alcohol in a



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public space, such as a park, a police officer is required to return that minor to the custody of their legal guardian. However, if a minor is admitted to a hospital with the symptoms of an overdose, they can be released from the hospital on their own accord and no notice is given to the minor's legal guardian. Healthcare providers have the right to report to parents; however, most do not follow that protocol and as a result parents are never informed of their child's life threatening disease. There appears to be significant inconsistencies in the ways in which we handle overdoses of minors. While there are issues with patient/doctor confidentiality, the Commission believes that parents do have a right to know if their minor has experienced an overdose.

The Commission urges that legislation be enacted to mandate that hospitals report to parents in the event of a minor overdose and enable parents to take the necessary steps to seek treatment for their child. This is not meant to deter young adults from seeking proper medical treatment, but provide parents with a tool that they cannot currently use. Currently, 75 percent of colleges and universities in the Commonwealth have policies in place that require that school officials notify parents in the event of a student receiving medical attention or any illegal activity that occurs on a college campus. Including such a regulation in the Commonwealth would allow for intervention by parents, enabling them to take the action necessary to help their child.

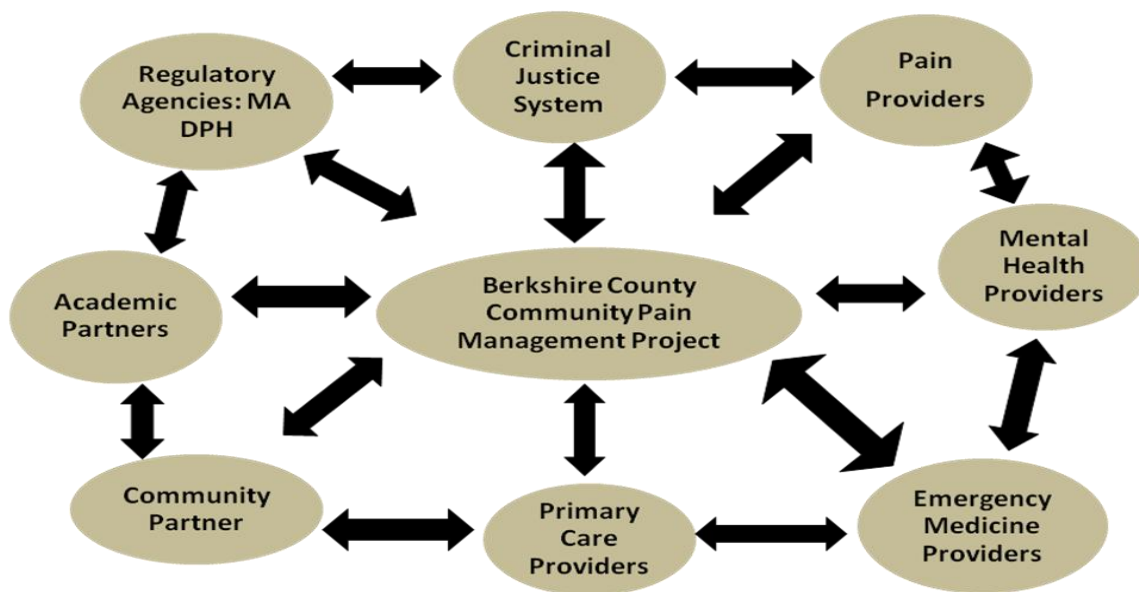
### ***Case Management***

It is widely accepted in the mental health profession that case management is necessary to assist individuals in moving through the complex treatment process. The same can be said of the substance abuse field and the need for intensive case management in a constantly changing, difficult to navigate and complex system. Case management could provide some of the necessary supports to assist individuals with substance use disorders in moving through a difficult process with many obstacles. The Commission recommends that the Commonwealth further investigate the state's capabilities to provide case management services to individuals identified with a substance use disorder and ensure that the case management provided in the Commonwealth includes the framework provided below various established programs.

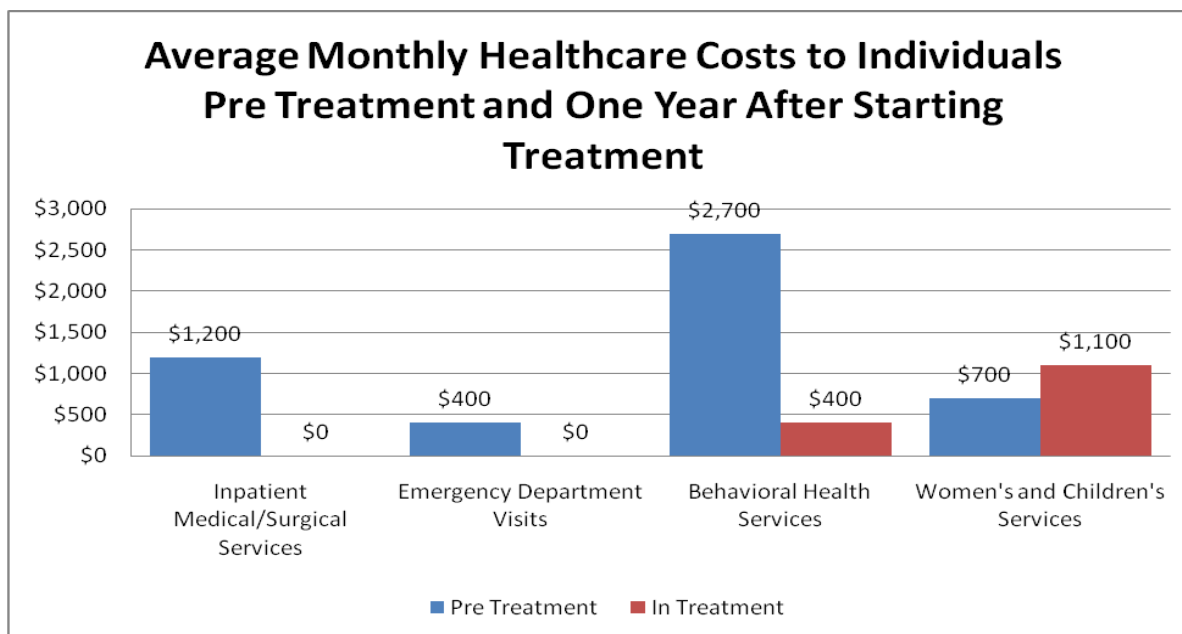
The Substance Abuse and Mental Health Services Administration (SAMHSA) defines case management as "a set of social service *functions* that helps clients access the resources they need to recover from a substance abuse problem."<sup>65</sup> It is understood that effective case management is comprised of (1) assessment, (2) planning, (3) linkage, (4) monitoring, and (5) advocacy.<sup>66</sup> Clinical practice and empirical observation suggest that individuals with substance use disorders who seek treatment have significant exterior issues in addition to using psychoactive substances. In addition to substance use disorders, individuals often suffer from additional health issues including liver disease, HIV/AIDS, and strains of hepatitis. Further, they may have problems with procuring housing, employment, and difficulty in their relationships.<sup>67 68</sup> When combined, these additional problems can exacerbate the underlying substance use disorder. The principal goal of case management is to keep an individual in effective treatment for the desired length of time. By focusing on the whole individual, case management allows for the external issues to be handled in combination with treatment, providing better long-term outcomes for the individual.

The Commission understands the role that case management plays in effective treatment, and believes that in order for case management to be effective, it must cross all agencies and allow the case manager to fully encompass all areas, including, housing, employment, medical, health insurance and substance use disorder treatment. Further, all agencies must be willing to work together for the common goal. SAMHSA along with the Center for Substance Abuse Treatment provides the necessary framework upon which for the Commonwealth to model a successful case management program. Given that many managed care organizations reimburse for case management services, the Commonwealth should be able to combine this funding with that of competitive federal block grants through SAMHSA.

Positive results have been seen in mental health and children's mental health services that involve intensive case management and the same results are possible with substance abuse issues in the Commonwealth. Additionally, various treatment providers in the Commonwealth have implemented a model of case management within their pain management and addiction treatment programs. Berkshire Health Systems (BHS), operating in Berkshire County, provides comprehensive health services in western Massachusetts. The BHS Pain Management Initiative includes inclusive case management and combines the "effort of healthcare providers, substance abuse specialists and members of law enforcement and the court system, designed to address the twin goals of improving chronic pain management services and combating drug diversion and misuse in the Berkshires."<sup>69</sup> The program has received acclaim for this innovative model which combines interagency services to patients seeking treatment for chronic pain with prescription pain medication and patients who have become addicted and are seeking treatment for their substance use disorder. Their model relies on the coordination with multiple disciplines to best facilitate treatment for their patients.



Berkshire Health Systems, Inc. Pain Care Resource Manual: A Practical Guide for Health Care Professionals. n.d. Print.



Berkshire Health Systems, Inc. Pain Care Resource Manual: A Practical Guide for Health Care Professionals. n.d. Print.

While still in the early years of the initiative, the program is seeing great success, not only in lowering the number of individuals with substance use disorders, but in health care costs for individuals in need of chronic pain management. Individuals who were enrolled in the program for one year have seen dramatic decreases in healthcare costs, especially in the area of behavioral health visits.

Case management is a cost saving tool. Individuals who are enrolled in a program providing case management have fewer multiple detoxifications, relapses and unnecessary treatment. Connecticut provides a good program model through their Targeted Case Management (TCM) Services. TCM Services are determined by “persistent substance dependence as evidenced by one or more of the disorders indicated below as defined by the current edition of the DSM and by a history of multiple unsuccessful treatment episodes.”<sup>70</sup> The Connecticut program provides diagnosis, treatment and follow up for individuals who have not responded to previous treatments, such as multiple detoxifications or outpatient care. In one year the case management program in Connecticut saw a 66 percent decrease in the total number of days that residential detoxifications were used.<sup>71</sup> The Commission recommends that a model, such as the one Connecticut or Berkshire Health Systems provides, be examined for possible application in the treatment model in the Commonwealth. It is the hope of the Commission that this tool would not only save money but provide more comprehensive services for those suffering from substance use disorders.

### ***Insurance***

Mandated coverage for substance abuse and mental health disorders has been an issue in state legislatures since the 1970s.<sup>72</sup> California was the first to pass legislation regarding mental illness

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in 1974, followed by 32 other states in the past 30 years.<sup>73</sup> There are two generally mandated types of state legislated insurance coverage. Mandated offering, which required that a plan offered in the state must treat physical and mental illnesses the same only if the insurance company offers coverage for those specific ailments in a given health care plan.<sup>74</sup> Mandated benefits on the other hand provides that coverage for mental and substance use disorders be complete and that minimum inpatient and outpatient coverage is specified by the state. It was not until 2001 that the Commonwealth recognized any form of substance use disorders as a form of mental health and required mandated benefits from the insurance industry.<sup>75</sup> Prior to the passage of the updated mental health parity laws of 2001, alcoholism and mental and nervous conditions were the only conditions covered under the mandated benefits model.<sup>76</sup> To Massachusetts's credit, the state is one of only nine states that have adopted parity statutes for substance use disorders.<sup>77</sup>

The Bureau of Labor Statistics data shows that the use of limits on substance abuse treatment has steadily increased since the 1980s, when such data began to be tracked.<sup>78</sup> According to the survey, in 1988, less than 60 percent of insured workers in medium and large firms were subject to limits on inpatient treatment.<sup>79</sup> By 2002, 89 percent of workers insured through medium and large firms had limits placed on their inpatient treatment for substance abuse.<sup>80</sup> This dramatic decrease in services, coupled with the increase in deductibles, have negatively affected the treatment of individuals suffering from substance use disorders, even as federal and state laws have attempted to increase benefits, end discrimination for substance use disorders and reduce costs for those seeking both inpatient and outpatient treatment.

In this rapidly changing system, health insurance companies are moving to a “carve-out” system to provide mental health and substance abuse services. “Carve-outs, the management of mental health care by firms that are legally and administratively separate from the firm managing general medical care, have become common in both the public and private health care sectors.”<sup>81</sup> Currently in Massachusetts the top insurance providers, including MassHealth, Blue Cross Blue Shield, Harvard Pilgrim Health Care, Tufts Health Plan and Fallon Community Health, contract their mental health and substance abuse services out to United Behavioral Health, Beacon Health Strategies and the Massachusetts Behavioral Health Partnership. Research on the effects of carve-outs is still not conclusive; however, given the testimony provided to the Commission, there is ample reason to be concerned that health insurance providers in the Commonwealth are able to reduce spending on mental health and substance abuse services by using the carve-out programs as gatekeepers and decreasing the services provided to individuals requesting mental health and substance abuse services.

Throughout the Commission's public hearings parents, loved ones, doctors, treatment providers and addicts continually brought up the various issues addressed above regarding insurance companies. One parent at the September 10, 2009 hearing stated that her son was denied further treatment after receiving an initial five-day detox until he had medically overdosed and was rushed to the hospital. At that point her insurance company approved a 14-day inpatient care; however her insurance later denied coverage for because the ways in which the provider coded the treatment. She is still fighting with her insurance company to have that treatment paid for and has gone to the Massachusetts Attorney General's office to get the state involved.

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The Commission understands the current climate in which Massachusetts finds itself in and the overwhelming support for cost containment and reform in the health care industry as a whole. Given these factors the Commission recognizes three areas of reform that must occur in the insurance industry to better enable those with substance use disorders to receive the treatment they, as individuals, needs:

1. Strengthen federal and state mental health parity laws to limit loopholes and provide comprehensive services in the form that is best suited to the individual suffering from substance use disorders. The state must ensure that insurance companies do not apply different utilization management standards to mental health and substance abuse treatments than they do to other medical interventions.
2. Mandate a medical necessity definition which includes a determination for behavioral health issues, providing for consistency across the state.
3. Ensure that should an individual chose the course of treatment that requires medication assisted treatment, proper coverage by insurance companies be mandated through the state.

While these reforms will not completely solve the discrepancies and inconsistencies within the insurance industry in regards to substance abuse treatment coverage, they will help to close the loopholes and work to end the heartache and frustration that many individuals in the Commonwealth experience.

*Strengthen state mental health parity laws to limit loopholes and provide comprehensive services in the form that is best suited to the individual suffering from substance use disorder.*

As referenced above, federal and state mental health parity are often at odds with one another. The Federally mandated requirements do not specifically include substance use disorders at this time and the state mandated parity is only now beginning to require coverage for substance use disorders. Federal issues will be discussed at length in a corresponding section of the report. As of July 1, 2009, substance use disorders have been added to the list of mandated coverage disorders under the Massachusetts Mental Health Parity legislation. The law requires the coverage include up to 30 days inpatient treatment and \$500 worth of outpatient treatment.

According to the Executive Office of Health and Human Services, Department of Mental Health;

“Health plans must provide mental health benefits on a nondiscriminatory basis for the diagnosis and treatment of biologically-based mental health disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (“DSM”). “Nondiscriminatory basis” means that copayments, coinsurance, deductibles, unit of service limits (e.g., hospital days, outpatient visits), and/or annual or lifetime maximums are not greater for mental disorders than those required for physical conditions, and office visit copayments are not greater than those required for primary care visits.”<sup>82</sup>

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The state is still in the process of implementing these new regulations, and insurance companies are beginning to change their internal regulations on substance use disorder coverage to fall in line with the state law. The Commission believes it is of the upmost importance to ensure that insurance providers continue to uphold the central tenet of this legislation. Additionally, the Commission believes that the state must actively enforce the legislation, through the Office of Patient Protection and the Attorney General's office. Without strict enforcement insurance companies will find loopholes to covering treatment

*Mandate a medical necessity definition which includes a determination for behavioral health issues, providing for consistency across the state.*

There are two issues that arise within state insurance law as it applies to medical necessity. First, is the issue of the definition of medical necessity and how to best define the term while requiring all insurance companies in the Commonwealth to comply with a standard definition. Pennsylvania requires that medical necessity for drug and alcohol treatment be determined by a licensed physician external from the insurer.<sup>83</sup> Given the Commission's understanding of the difficulties that loved ones and individuals with substance use disorders face in securing adequate treatment, a recommendation is made to include a referral process by the Division of Insurance, in coordination with the Bureau and Substance Abuse Services, to the standardized definition of medical necessity.

Second, is the issue of the appeals process when individuals are denied coverage by their insurance company. While the Office of Patient Protection does allow for external reviews of denials of treatment for medical necessity, the Commission recommends strengthening the regulations to include more stringent guidelines. Further, if the above statutory change is made, a change in the appeals process will need to be made to reflect the state's comprehensive medical necessity criteria. Again, coordination with the Division of Insurance and the Bureau of Substance Abuse Services is needed. Vermont has the most rigorous criteria for appeals involving mental health services and substance abuse treatment. Their criterion establishes an independent seven member review board for mental health services and substance abuse treatment.<sup>84</sup> The Commission recommends using Vermont's statute as a model for legislation in the Commonwealth on medical necessity review boards.

Finally, an issue that was not widely addressed but deserves further attention is the distinction between fully-insured/fully-funded plans and self-insured/self-funded plans. Currently there are two ways in which an employer may contract health insurance benefits for employees. Fully-insured/fully-funded plans require that all premiums be paid to a specific insurance company who pays the various providers for treatment. Self-insured/self-funded plans require that employers pool all premiums and put said premiums into an escrow account and then contract with a health insurance company as a third-party provider. The original employer pays for all services out of the escrow account. The second type of employer supplied health insurance is not under state regulations or mandates and because this type of plan can save the employer the profit margin that they would have to pay to the insurance company, they make up nearly 50 percent of all employer supplied health insurance plans in the Commonwealth. The Commission recommends that further research be done, in conjunction with the Commonwealth's delegates in

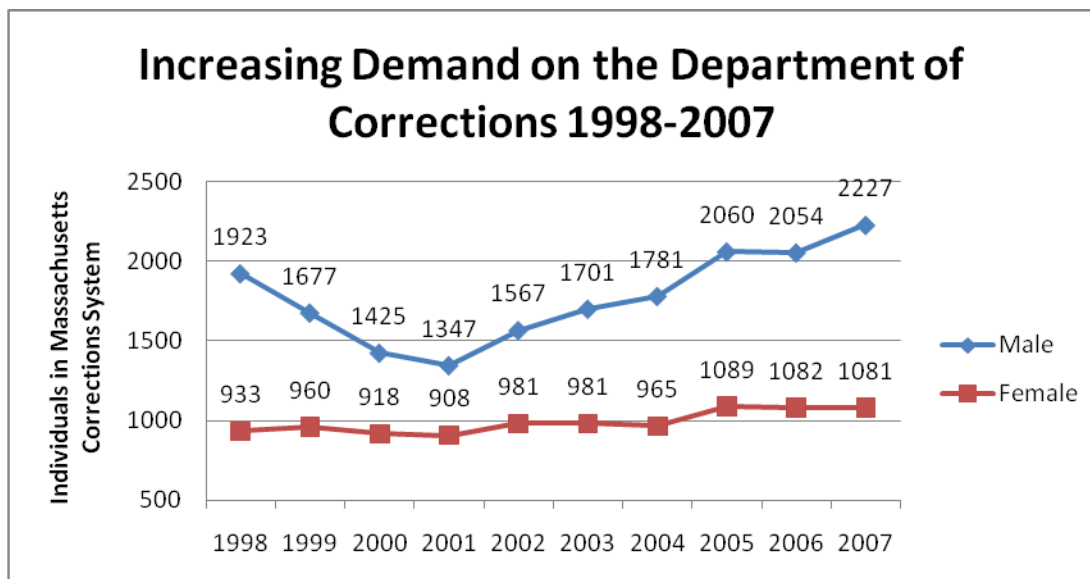
Congress, to determine the best course of action for federal laws to close loopholes involving self-ensured/self-funded plans.

*Ensure that should an individual chose the course of treatment that requires maintenance and harm reduction medication, proper coverage by insurance companies be mandated through the state.*

Of the six insurance companies surveyed, four provide some level of methadone maintenance coverage and five of the six provide some level of buprenorphine/suboxone maintenance. Most companies stated that co-pays are required for maintenance medications and that there were no plans in place for individuals to move off maintenance medications at any time. For many individuals this is the best course of treatment and the Commission applauds the insurance industry for investing in this valuable tool towards sobriety. However, the Commission recommends that this is not the only tool for individuals to use and it can be misused and abused, just as other prescription opiates can. There should be strict guidelines to ensure that these medications are regulated and not abused. These alternative treatments must be covered by all insurance plans in the Commonwealth. As mentioned above, comprehensive follow up care from doctors and case managers is also a necessary component of effective opioid treatment and working with insurance companies to ensure that this occurs should be included in Department of Public Health regulations.

### ***Addiction and the Criminal Justice System***

The number of adults involved in the criminal justice system has soared from approximately 1.8 million in 1980 to 7.3 million in 2007.<sup>85</sup> During that same period, the number of people in prison for drug offenses rose roughly from 41,000 in 1980 to 500,000 today.<sup>86</sup> Nearly 1 in 31 adults in the United States is currently under some form of correctional supervision. In Massachusetts, that number is 1 in 24, up from 1 in 127 in 1982.<sup>87</sup>



Commonwealth of Massachusetts. Department of Correction. *DOC Reentry Initiative*. DOC, 2008. Print.

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The connection between drug abuse and crime is well known. Substance abuse is implicated in at least three types of drug related offenses: a) offenses defined by drug possession or sales, b) offenses directly related to the substance use (prostitution to get money for drugs, stealing to get money for drugs, etc.), c) offenses related to crimes committed while under the influence of substances (DUIs, etc.). Individuals who use illicit drugs are more likely to commit crimes and it is common for many offenses, including violent crimes, to be committed by individuals who had used drugs or alcohol prior to committing the crime, or who were using at the time of offense. In fact, according to the National Institute of Health, over 70 percent of inmates in state and local prisons abuse drugs regularly.<sup>88</sup> Clearly, harsh punishment for drug offenders swells state and county prison populations, but does little, if anything, to reduce drug use. The Commission recognizes the need for reforms in drug policy and sentencing practices. These recommendations will be reviewed in detail below.

It is estimated that nationally 97 percent of individuals who are incarcerated will eventually return to living in the community.<sup>89</sup> In Massachusetts approximately 8 percent of the Department of Correction population is serving first or second degree life sentences; therefore, 92 percent of the inmates within the prison system will return to Massachusetts communities. More than 2,800 inmates were released in 2008 from the state corrections agency. A much higher number of individuals are processed through the Commonwealth's jails and Houses of Corrections on a routine basis. Most of these individuals are returning to Massachusetts neighborhoods with an untreated substance use disorder, which significantly increases the likelihood of their engaging in a variety of high risk behaviors, including criminal offending. However, there is an abundance of research which indicates that substance abuse treatment works for drug abusing offenders, even when it is entered involuntarily. Research also shows that the outcomes for drug abusing offenders transitioning to the community following incarceration can be dramatically improved through participation in aftercare programs. Left untreated, drug abusing offenders can relapse and return to criminal behavior, often within the first 72 hours after release. This jeopardizes public safety, leads to re-arrest and further stretches an already over-burdened criminal justice system. In light of these facts, the Commission recommends adopting practices such as the Bureau of Justice Assistance's Sequential Intercept Model, where interventions can occur at any and every point along a person's involvement with the criminal justice system, and enacting mandatory post-release supervision, that could compel a person leaving prison into treatment. These recommendations will be reviewed in detail below.

Spending on corrections has been the fastest growing or second fastest growing item in state budgets over the last fifteen years. In FY2009, the budget for corrections spending in Massachusetts was greater than the budget for higher education.<sup>90</sup> Despite this increased spending, recidivism rates have remained largely unchanged. Research shows that strong community supervision programs for lower-risk, non-violent offenders cost significantly less than incarceration. According to NIH, \$1 spent in treatment results in savings of at least \$4 to \$7 dollars for the state.<sup>91</sup> The Commission supports the formulation of effective, cost-efficient recommendations that support treatment and insure public safety for this unique population. These recommendations will be reviewed in detail below.



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## **Sentencing Reform and Post-Release Supervision**

In the mid 1990s sentencing reform focused on “truth in sentencing.” Reformers sought to restore integrity to the criminal justice system through statutory changes that ensured that the sentence that was indicated was the sentence that was served. This meant increasing incarceration capacity through alternative sentencing, amending arcane sentencing rules, and funding new prison construction through municipal bonds. Today, scarce resources mean that reform must do more than create additional capacity. For sentencing reform to be effective, it must promote evidence-based approaches that target recidivism and debilitated offenders.

Sentencing reform should include a variety of components, including those which allow the Department of Correction to “step down” inmates through the various security levels prior to release. In this way, individuals are better prepared to reenter the community, having progressed to minimum security and pre-release status. Such preparation prior to release is shown to reduce recidivism by gradually introducing the individual back into the community environment. Individuals currently serving mandatory minimum sentences are not allowed to participate in such programs, thus increasing their likelihood of reoffending. Many if not most of these “mandatory” sentences are related to drug use in one way or another. Given that these same individuals will be released to the community at some point, it is in the best interest of the state to better prepare them for such release by availing them of necessary reentry services through lower security programs.

Despite the overwhelming evidence that substance abuse programming is effective, if for a sufficient duration, even when required, the Department of Correction was only able to provide such services to approximately 45 percent of the inmates in need of such services in 2008 due to a shortage of resources. Since that time, the outpatient services component has been eliminated due to mandated executive funding cuts and budget reductions, further reducing the availability of critical services. Given that the majority of individuals incarcerated have either offended while under the influence of drugs or alcohol or committed crimes to procure such substances, enhanced residential and outpatient substance abuse treatment programs are essential during incarceration. Linkage with aftercare services upon release and the incentive to participate, as dictated by post-release supervision, is extremely important.

The Massachusetts Trial Court, Office of Community Corrections (OCC) is a government agency founded in 1996, to establish and implement intermediate sanction programs for the intensive supervision of probationers, parolees and inmates returning to the community after a period of incarceration. The OCC operates 27 Community Corrections Centers (CCC) statewide in collaboration with county sheriff's and community-based human service agencies. CCC's combine sanctions and services through Intermediate Sanction Levels, as promulgated by the Massachusetts Sentencing Commission. Sanctions include community-service, day-reporting, drug and alcohol screening and electronic monitoring. Services include substance abuse treatment, education, life-skills training and job development.

In FY2009 more than 4,000 criminal offenders received substance abuse treatment as a component of intensive supervision at a CCC. In order to increase access to substance abuse treatment at another point in the criminal justice process, consistent with the Sequential Intercept

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Model, the Commission recommends amending existing statutory law at Chapter 211F, Section 3 so that individuals on pre-trial probation can be referred to a CCC at ISL III or IV. Currently, by law, probationers must be “sentenced to” an intermediate sanction program as a condition of probation. A change in this law would permit substance abuse intervention not only for probationers who are “sentenced” post-disposition but those who are awaiting trial and under pre-trial probation supervision. This simple change would thereby create a ready-made, substance abuse treatment diversion program for those involved in the criminal justice system.

Additional substance abuse treatment intervention can be promoted through the reintroduction of “split” and “suspended” sentences to state prison adjudicated in the superior court. Under current law, superior court judges do not have the authority to suspend a sentence of incarceration in whole or in part. Thus, superior court judges must choose exclusively between probation and incarceration. As a result, judges who might opt for a combination substance abuse intervention through intensive supervision and a period of incarceration are likely to take the “safer” approach of incarceration alone. The Commission recommends the restoration of suspended and split sentences. This move would provide judges with the authority to combine intensive supervision probation with a period of incarceration for single offense convictions in the superior court. This change will permit judges to more readily access substance abuse treatment either before or after a period of incarceration for a single offense conviction.

So-called “split” sentences provide the opportunity for additional post-release supervision. The Commission recommends that this post-release supervision be administered by probation so that the substance abuse treatment afforded through the CCC can be implemented for a time duration that is consistent with evidence-based practice. According to the National Institute of Drug Abuse, substance abuse treatment in criminal justice applications is effective when it lasts long enough to produce stable behavioral changes.<sup>92</sup> Consistent with this principle the OCC mandates the use of benchmarks to determine when a participant is able to make a transition to standard supervision. While all criminal justice supervision can be intensified through the CCC, only probation has the institutional focus and apparatus to coerce longer duration substance abuse treatment. The duration of parole or sheriff department supervision is often less than 90 days, which is inconsistent with evidence-based practice for substance abuse treatment in criminal justice supervision as articulated by NIDA.

## **Voluntary and Involuntary Commitments**

There are currently two ways that an individual with substance use disorder can be placed into a locked-down setting, either through a civil ruling or as a result of a criminal offense. Massachusetts General Laws Chapter 123, Section 35 (“Section 35”) permits the courts to involuntarily commit someone whose alcohol or drug use puts themselves or others at risk. Such a commitment can lead to an inpatient substance abuse treatment for a period of up to 30 days. Under the law, the person can be committed to a licensed treatment facility or, if none are available, to a separate unit at the correctional facility.

Those who commit a crime, and are found to be addicted to a controlled substance, can be placed in a locked-down treatment center through a number of innovative programs currently operating in the Commonwealth. There are 20+ drug courts in Massachusetts that can place an individual

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with substance use disorder in a locked-down facility for treatment as an alternative to incarceration. The Legislature, in the FY2007 Supplemental Budget, provided \$1 million to start a pre-arraignment pilot program in the Essex County District Attorney's Office. The District Attorney is able to direct non-violent offenders into a locked-down substance abuse treatment facility, in lieu of arraignment and a subsequent Criminal Offender Record Information (CORI) record. Additionally, these offenders agree to enter and remain in treatment as well as pay restitution for any crimes committed in exchange for their arraignment being held in abeyance. Thus far, this program has been a great success and merits consideration for its application state-wide to serve as a siphon for the secure treatment centers.

In the summer of 2009 the Department of Corrections announced the closure of the Massachusetts Alcohol and Substance Abuse Center (MASAC). An immediate public outcry occurred, as many parents and loved ones who turn to the involuntary commitment statute as a means of protecting their loved ones when they have nowhere else to turn. Due to the overwhelming support for this program the Department of Corrections has put an indefinite hold on the closure of the facility. While this is a short-term victory for those who need this type of secure treatment, long-term solutions must be put in place.

Additionally, two treatment centers, the Men's Addiction Treatment Center (MATC) in Brockton, and the Women's Addiction Treatment Center (WATC) in New Bedford, have recently opened to provide secure treatment facilities for those individuals who are civilly committed. Approximately 92 percent of individuals who enter MATC successfully complete the program and 13.6 percent voluntarily extend their stay for further treatment.<sup>93</sup> While these units are providing much needed services for this population of individuals, including detoxification, case management and aftercare, they are constantly at capacity and in need of resources.

These programs are providing many individuals with a viable option to treat their opiate addiction. However, without proper funding these programs will not be able to sustain their current treatment levels. The Commission recommends that in light of current budgetary constraints secure treatment facilities, including MASAC remain in place until suitable alternatives can be established.

## **Jail Diversion**

The Commission believes that we must drastically alter the manner in which we deal with those suffering with substance use disorders in our criminal justice system. The diversion of low-level offenders from a correctional setting into treatment is an excellent first step towards reforming a system in dire need of attention.

A jail diversion program will not only save the state tens of millions of dollars in correction costs, but also ensure that those with substance use disorders are receiving proper treatment. The findings thus far of the OxyContin and Heroin Commission have substantiated that the state is not providing a comprehensive treatment infrastructure and is, therefore, hemorrhaging money from this broken system. National estimates show that states disburse up to 15 percent of their budgets on substance abuse related costs. In Massachusetts this amounts to \$4.2 billion of our

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state budget being used on corrections, public safety, children and family services, and health care costs associated with substance abuse.<sup>94</sup>

Jail diversion will create immediate savings and will take the pressure off of our overburdened corrections and court systems, allowing those branches to concentrate on their core missions. The Department of Corrections is clearly fulfilling a role that they are ill-equipped to handle. Evidence shows that 17 percent of all inmates claim to have committed their crime solely to obtain money to buy drugs. The neurobiological evidence proves that the impulse to get high becomes a survival function for individuals affected by this disease. For the most part, these individuals are not bad people, they are sick and in need of proper treatment.

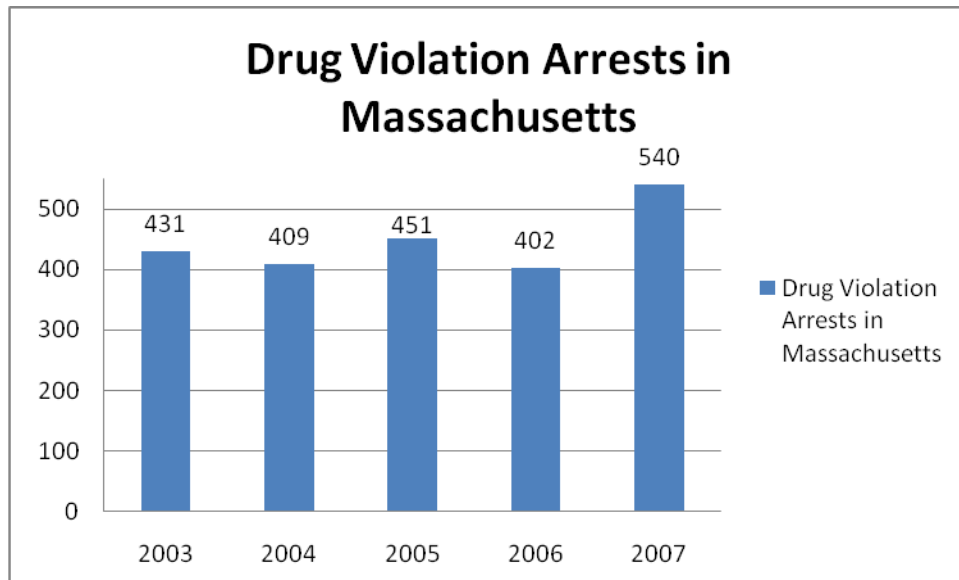
A jail diversion model that requires up to 90 days of inpatient treatment, followed by a year of case management and support has the ability to change the way Massachusetts handles substance abuse issues. Many other states are adopting this model for treatment and seeing great success. We cannot afford to let Massachusetts fall behind other states in this area. We are a state that provides strong social services, excellent universal healthcare, top-rated schools, outstanding workforce development, mental health services, and resources for low-income individuals. Making a substantial change in our approach to this epidemic will make Massachusetts a national leader on this issue, and an example for other states to follow.

In 2007, Texas chose to address a projected shortfall of 17,000 available prison beds by 2012 by taking \$241 million out of the prison budget and spending it on increased drug and alcohol treatment programs and other diversion efforts. It also expanded its drug courts.<sup>95</sup> Texas officials estimate that expanding the treatment and diversion programs will eliminate the 2012 bed shortfall and in will save the state \$430 million over FY2008 and FY2009.<sup>96</sup>

The Commission believes that we must care for these sick individuals through a jail diversion program and that through this program, the Commonwealth will save money and lives.

### ***Interdiction and Law Enforcement***

Law enforcement officials play an important role in the substance abuse equation as they are often the first responders in instances of illegal activity and play a crucial role in the implementation of policies throughout the Commonwealth. In 2008, the United States Drug Enforcement Agency seized, 211.9 kilograms of cocaine, 7.6 kilograms of heroin, 2.9 kilograms of Methamphetamine and 988.6 kilograms of marijuana. Consequently, arrests for drug violations have risen in the last year with 540 taking place in 2007.<sup>97</sup>



United States. Drug Enforcement Administration. *DEA Briefs and Backgrounds –Massachusetts*. Drug Enforcement Administration, 2008. Web. 19 Oct. 2009.

With the majority of state budgets concerning substance abuse going towards the aftermath of substance abuse, including crime and law enforcement, the Commission has a particular interest in ensuring that there is efficient funding and programming in place.

## Internet

The availability of opioid analgesics on the internet is a concern that has garnered significant attention on both a state and federal level. The internet is riddled with online pharmacies that provide access to opioids, including those that do not require a prescription. In 2005, The Drug Enforcement Agency (DEA) concluded “Operation CYBERx” successfully shutting down over 22 pharmacies and nearly 5,000 web sites that were not requiring prescriptions.<sup>98</sup>

While the Commission acknowledges that the complexities involved in policing the internet remain largely a federal matter, it is imperative that emphasis is placed at the state level to monitor these transactions. The Commonwealth can be better served by improving the methods of communication with federal enforcement agencies responsible for targeting these internet suppliers which are often found to be the route source for expansive criminal enterprises.

## Law Enforcement

The role of law enforcement in combating the proliferation of illegal opioid use is critical, yet often complicated and expensive. The Commission heard testimony from law enforcement officials who cited difficulty in disrupting the illegal sale of opioids without devoting significant time and resources to developing what eventually leads to a lengthy investigation. Due to the highly organized structure of the groups involved in trafficking opioids, the investigators rely heavily on long drawn out wire tap operations that become a particularly costly endeavor.

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With this in mind, the Commission feels it is imperative that work be done to expand the available tools our law enforcement officers have to combat this illegal activity. Law enforcement officials need to work in conjunction with the medical professionals who prescribe these pain medications. Improving educational awareness and providing access to the Massachusetts Prescription Monitoring Program (PMP) would be the next step in the drive to better equip our law enforcement professionals. With limited funding available and the majority of the cost burden associated with assistance based programs, access to the PMP would be a very effective tool for law enforcement.

### ***Long-Term Treatment***

Research from the mid-1970s demonstrates that treatment can help patients addicted to drugs to “stop using, avoid relapse, and successfully recover their lives”.<sup>99</sup> However, more often than not addictions go unnoticed or untreated. Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Survey on Drug Use and Health (NSDUH), indicates that in 2007, 23.2 million people in the US (9.4 percent of the population) age 12 and old require treatment for drug or alcohol use.<sup>100</sup> Of the 23+ million people needing addiction treatment services only 2.4 million (10 percent of the population needing treatment) received the necessary treatment to successfully move into recovery, thus, 20.8 million persons (8.4 percent of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive it.<sup>101</sup> Long term treatment programs are needed to provide a continuum of care to move the individuals from addiction to recovery.

Long-term treatment programs are designed to provide individuals with a treatment program that includes residential treatment, stabilization services, vocational rehabilitation and social support structures. These programs provide a continuity of care that extends through the life cycle of an individual with substance use disorder. Studies show that the best long-term programs are characterized by “a combination of therapies and other services to meet an individual patient’s needs. Specific needs may relate to age, race, culture, sexual orientation, gender, pregnancy, other drug use, comorbid conditions (e.g., depression, HIV), parenting, housing, and employment, as well as physical and sexual abuse history.”<sup>102</sup> Among the needed treatment programs, the best programs focus on substance abuse monitoring, case management, support groups, pharmacotherapy and behavioral therapy. Coupled with these treatment efforts, are the support structures needed for the individual to move into successful recovery. These support structures include family and child care services, vocational rehabilitation, mental health services, housing, financial and medical services. See all the components of comprehensive drug abuse treatment listed below.<sup>103</sup> The Commission recommends that a comprehensive approach to long-term treatment, include the following:

- Treatment program attributes: substance abuse monitoring, case management, support groups, pharmacotherapy and behavioral therapy.
- Recovery support attributes: family and child care services, vocational rehabilitation, mental health services, housing, financial and medical services.

Several studies have demonstrated the importance and efficacy of long-term treatment programs, especially those that institute a continuum of care program that serve the individual’s specific

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needs and vulnerabilities. A study by the Institute for Behavioral Health found that “adolescents who received another service within 14 days of their residential discharge had approximately a 92 percent higher likelihood of being in recovery at the end of the 3-month follow-up than adolescents who did not receive another service within this time frame.”<sup>104</sup> In a similar report the *Journal for Drug Education* found a significant relationship between social supports, economic self sufficiency and substance abuse outcomes in long-term programs.<sup>105</sup> Evidence about this relationship has been provided before, yet many programs have reduced their services and lengths of stay.<sup>106</sup> This study found that “reductions in substance abuse were associated with measures of self-sufficiency...among women who participated in our study; economic outcomes, substance abuse, and general functioning went hand-in-hand.”<sup>107</sup> This research demonstrated that eliminating services, specifically employment related services will negatively impact the clientele.<sup>108</sup>

Short-term treatment should not be ignored or dismissed in regards to the overall spectrum of treatment options. However, with individuals who have a history of substance abuse, long-term treatment and continuum of care must be available. In 2001, the *Journal Psychiatric Services* looked at outcomes for short-term and long-term programs. The study determined that “patients in the long-term program were significantly more likely to become engaged in treatment, and after discharge they were more likely to maintain abstinence and less likely to experience homelessness.”<sup>109</sup>

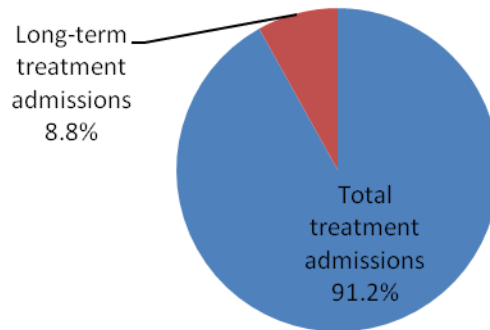
A middle aged woman who is a resident of Phoenix House in Springfield testified at the commissions hearing at the State House on March 27, 2009 about her experiences with treatment programs. “The Phoenix House is the first long-term treatment facility I have tried and it is EXACTLY what I need... In my opinion is the only thing that gives addicts a chance at a so called normal life. Giving us structure and a chance to work on our issues and take care of things that we have put off for so long gives us hope that we can leave here and stay drug free.”

Substance abuse treatment needs to be flexible and adjusted to the needs of the individual. Long-term treatment can provide the flexibility and adequate time to obtain the services needed to support the individual in their recovery effort. Research suggests that the length of treatment should not be pre-determined and should meet the need of the individual.<sup>110</sup> Similarly, “for residential or outpatient treatment, participation for less than 90 days is of limited effectiveness, and treatment lasting significantly longer is recommended for maintaining positive outcomes.”<sup>111</sup> Recovery from drug addiction is a process that takes time and in some cases may require multiple episodes of treatment.<sup>112</sup>

In Massachusetts FY2007 there were 45,902 admissions to treatment programs, reporting heroin use. Of these admissions 8.8 percent (4,047) were admitted to Long-Term Residential Services for longer than 30 days.<sup>113</sup> These programs included Recovery Homes, Therapeutic Communities, social models, residential programs specifically for offenders, and women and family oriented shelters. It is interesting to note there are only 1,885 of long-term treatment beds available in Massachusetts. With calls from providers and consumers for more long-term treatment options, and no shortage of people needing the beds, the number of long-term treatment programs needs to be increased to meet this rising demand.

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## Percentage of Individuals in Long-Term Residential Treatment FY2007



Commonwealth of Massachusetts. Department of Public Health. *Substance Abuse Treatment Fact Sheet - FY 2007 Heroin Users*. Bureau of Substance Abuse Services, 2008. Web. 25 Sept. 2009.

John McGahan, President of the Gavin Foundation testified before the Commission on March 27, 2009 on his experience in working with long-term treatment programs. He stated that there are only 105 residential beds for adolescents in the Commonwealth. Cushing House, a 30-bed adolescent program run by the Gavin Foundation, is currently running at maximum capacity with a two month waiting list. The waiting list for Gavin House, a 33 bed residential program for men is just as long.<sup>114</sup> McGahan also commented that regulatory options need to consider the importance of cost effective treatment versus the high cost of incarcerations, social consequences, and that those affected are real people, mothers, fathers, sons and daughters. Long-term treatment programs need to be expanded to address this epidemic that is continuing to grow.

“Long-term residential treatment provides care 24 hours a day, generally in non-hospital settings. The best-known residential treatment model is the therapeutic community (TC), with planned lengths of stay between 6 and 12 months. TCs focus on the “re-socialization” of the individual and use the program’s entire community—including other residents, staff, and the social context—as active components of treatment. Addiction is viewed in the context of an individual’s social and psychological deficits, and treatment focuses on developing personal accountability and responsibility as well as socially productive lives. Treatment is highly structured and can be confrontational at times, with activities designed to help residents examine damaging beliefs, self-concepts, and destructive patterns of behavior and adopt new, more harmonious and constructive ways to interact with others. Many TCs offer comprehensive services, which can include employment training and other support services, on site.”<sup>115</sup>

While many of these concepts are not foreign to treatment programs in the Commonwealth, the concept of long-term treatment is considered an expensive course of action. In-patient treatments, involving intensive 24-hour care can also be a commitment that an individual with a



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substance use disorder may not be willing to take. This being said, for some individuals it is the only way to recover from their disorder and maintain sobriety long term.

## ***Youth***

OxyContin, other prescription medication and heroin abuse has continued to be a prevailing problem with the Commonwealth's youth. In 2007, there were 4,544 substance abuse treatment admissions in the Commonwealth for citizens ages 15-19.<sup>116</sup> This age group accounts for 4.3 percent of all substance abuse treatment admissions.<sup>117</sup> An increasing number of young adults are being exposed to prescription painkillers. The Commission heard from parents and family members whose young adults became addicted in a variety of ways. According to statistics from the National Survey on Drug Use and Health (NSDUH), of youths misusing prescription opioids, one third reported that they obtained the drugs for free from family and friends. The second most common source for obtaining prescription opioids was through a physician.<sup>118</sup> Whether as the result of using painkillers after a major surgery or from experimentation with friends, the devastating and long-term effects of opioids in one's system are tremendous and the Commission feels that drastic steps must be taken to curb this epidemic in today's youth.

## **Education and Prevention**

There are a variety of issues that affect young adults. First, is the need for prevention through schools and other community measures educating students about the dangers of substance abuse and working to deter them from trying drugs. Additionally, there is a need for licensed drug and alcohol counselors to be present in schools and provide the needed support to students who may be afflicted with addiction. The Commission found that many early points of interception for the Commonwealth's young adults are not being addressed.

Throughout the public hearing process the Commission heard many stories from community organizations and schools about the need for education and prevention programs. Due to strains in the budget since 2003, national programs such as D.A.R.E. have been cut from the state budget and as a result all but died out from the Massachusetts elementary and middle school curriculums. Many schools were not able to keep up with the burden of paying for the program themselves. Raising awareness about the harms of drugs, alcohol and substance abuse is an issue that must be addressed at an early age. Additionally, given the changes in substance abuse in the Commonwealth, these programs must be updated to include illicit use of prescription drugs. D.A.R.E. Massachusetts has seen a recent resurgence and to date between 75 and 95 towns use the program in their schools. This is a drastic cut from the mid-1990s when most of the 351 towns in the Commonwealth accessed the program.<sup>119</sup> The program is attempting to modernize many of their original lesson plans, including topics on prescription medications, bullying and lesson plans for parents, however without widespread use, the program lacks the coherency to be broadly analyzed. The Commission recommends that a statewide program be put into place and required throughout all levels of a child's education, including the upper grades of elementary school. The curriculum should include lessons on the dangers of prescription medication abuse, as well as many of the other modern abused narcotics. A recent study from the National Institute of Health suggests that when school-based prevention programs began in elementary school they significantly reduced the number of students that engaged in substance abuse, violent behavior,

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or sexual activity.<sup>120</sup> It is the hope of the Commission that with a program in place in all schools, the rate of drug use would decrease among our youth.

In addition to improving education programs in schools, the Commission recommends that licensed drug and alcohol counselors are present in each middle school and high school throughout the state. While it is not necessary that a counselor be a separate staff member within the school, providing a teacher, health professional, principle or other staff member with the necessary training to recognize drug and alcohol abuse in youth, and assist parents and students with the available resources should a problem arise. Pennsylvania has a comprehensive approach to counseling and support services in schools, including a professionally trained team which includes school staff and experts from community substance abuse agencies that work together to monitor issues in the school and provide the best learning environment possible.<sup>121</sup>

### **Recovery High Schools**

Recovery high schools are not a new concept to Massachusetts, however in recent months they have received increased attention and praise both within the state and nationally. In April 2009, CNN did a large print and television story on the students at the Beverly Recovery High School.<sup>122</sup> The three Massachusetts Recovery high schools are boasting great successes and in the 2006-2007 school year 72 percent of the youth referred to the three schools completed the school year.<sup>123</sup> Massachusetts Recovery high schools follow the traditional public high school format, meeting the Massachusetts Department of Elementary and Secondary Education Curriculum Framework, but incorporate the traditional addiction recovery 12-step program. These schools have seen success since their inception in the Commonwealth in 2006. In recent months, legislation in Massachusetts has been approved to require public school districts to put the portion of expenses for a given student attending a recovery high school towards that student's education at one of the three state recovery high schools. This is a vast improvement over the previous system and will aid the recovery high schools in continuing their mission and expanding the number of students they are able to serve. The Commission met with several students who attended a recovery high school in the Commonwealth and each student spoke that their success was due entirely to the drug-free zone the schools provided and are now giving back to the schools, as teachers, mentors and staff members. The Commission recommends that the state continue to support these worthwhile schools, by increasing the number of recovery high schools in the Commonwealth through more funding and legislative support.

Throughout the hearing process the Commission heard from a variety of parents who expressed similar sentiments. We must do all that we can when children are young to expose them to the dangers of drug and alcohol abuse. Further, if a child has issues with alcohol or substance abuse, schools must be equipped to aid parents in knowing their options and assisting them in getting treatment for their child. Finally, when necessary, students should be given the option to attend an area recovery high school, as their success is clearly seen in the positive and successful graduates of these programs. The Commission believes that with these recommendations, the youth of Massachusetts who may become addicted or are currently addicted can be given a better chance of success.

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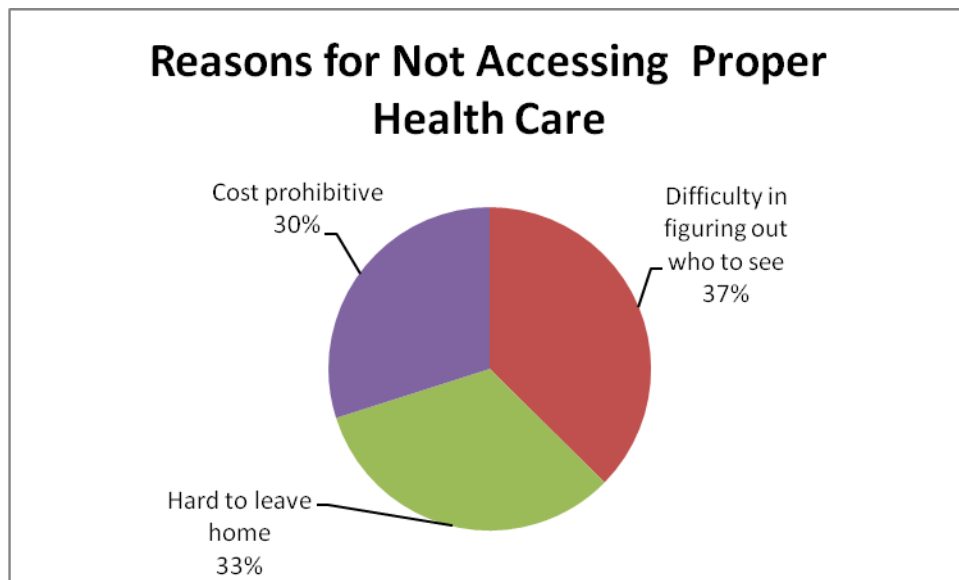
## ***Unique Populations***

Throughout the Commission's public hearings, a variety of individuals spoke about so-called unique populations, which has their own special needs and considerations. The hearing in Hyannis focused solely on these unique populations dealing with substance abuse, including veterans and those with co-occurring disorders. The following section outlines the individual issues surrounding unique populations as they pertain to substance use disorders. Overall, the Commission believes that more attention must be paid to these individuals and the special needs they have.

## **Disabled Populations**

In America there are 7 million people with disabilities (PWD) who receive federal support and health care benefits from the Supplemental Security Income (SSI) program.<sup>124</sup> Individuals who receive SSI have a long-term disability which will bring them in contact with state and federal health care systems as well as social service systems. These individuals receive treatment for their disabilities in many forms; however, the prevalence of substance abuse disorders among this population can increase the cost and complexity of those services.<sup>125</sup> One report focusing on substance abuse rates among people with multiple sclerosis (MS) found that "substance abuse may be present in up to 19 percent of this sample and contribute to high rates of depression. There may be greater risk of harm due to substance abuse in people with MS because of the potential magnification of motor and cognitive impairments."<sup>126</sup> With the prevalence of substance abuse among PWD, it is critical for treatment programs to be cognizant of the access barriers to treatment for this population. In addition much of the treatment for co-occurring disorders focuses on substance use disorders and mental health disorders, not on physical disabilities.<sup>127</sup>

Much of the difficulty in providing services for PWD is meeting the physical needs and access issues related to this population. A study by the Massachusetts Department of Public Health, in conjunction with the Center for Survey Research out of the University of Massachusetts Boston found that there were three main barriers to accessing needed health care.



Massachusetts Department of Public Health. (MDPH) Office of Health and Disability. *Study of the Unmet Needs of Adults with disabilities in Massachusetts*, 2007. Center for Survey Research. University of Massachusetts, Boston. July 2008.

Given the differences that PWDs face, substance abuse treatment programs for PWD must look to provide adequate access, treatment specific programs that take into consideration the physical impairments of the population.

Another barrier to accessing treatment for PWD who also have a substance use disorders is that “typical policy in state vocational rehabilitation (VR) agencies requires people with substance use disorder to be “clean and sober” for six months prior to receiving services.”<sup>128</sup> For PWD to receive vocational training as a point of increasing independent living and quality of life, these services need to be available during, not after substance abuse treatment. This research demonstrated that vocational rehabilitation programs should be integrated into substance abuse treatment, not provided after the fact to improve an individual’s independence and quality of life.

Recent studies have demonstrated that current best practice programs for PWD seeking treatment will merge the biopsychosocial theoretical perspective of addictive disorder. According to the study conducted by the Department of Alcohol and Drug Services in California, this model includes “supportive counseling, motivating client readiness for change and coping skills-training techniques. The goals of treatment are to establish and maintain abstinence from the illicit use of all psychoactive drugs, foster development of (nonchemical) coping and problem-solving skills to stop and ultimately eliminate impulses to “self-medicate” with psychoactive drugs, and to enhance and sustain client motivation for change.”<sup>129</sup>

A report by the Oregon Health and Science University in Portland provided guidelines for removing access barriers to substance abuse treatment. This report cited that “interventions to address disparities in treatment access will need to coordinate across multiple communities to address the numerous barriers.”<sup>130</sup> The study cited the following findings.

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1. Vocational rehabilitation counselors and social service case managers will need to recognize and address substance in their clientele and increase referral to treatment.
  2. Treatment programs will need to address the negative attitudes of their staff and improve accessibility of their facilities, policies, and materials.
  3. Substance abuse treatment professionals must pay close attention to the unique aspects of the lifestyle of PWDs, which may affect the outcomes of SA treatment.
  4. Provider sensitivity to treatment barriers (political, attitudinal, or physical) is crucial while devising evaluations and individual treatment plans. Leaders in the disability community have a role to play in informing their members about SA and treatment.<sup>131</sup>

The Executive Office of Health and Human Services (EOHHS) is striving to ensure that reasonable accommodations for access to programs and services needed by PWD are met. In accordance with the American with Disabilities Act, EOHHS is “committed to facilitating compliance with these important Civil Rights Acts among agencies that provide prevention, intervention and treatment services for alcoholism and other drug abuse.”<sup>132</sup>

The Commission recognizes that there is a lack of specialized services for this population. Access to care is a major burden for individuals with substance use disorders who are also disabled. As with the other unique populations, many of the issues coincide with one another. The Commission believes that as with all substance abuse issues, treatment must be individualized and must adapt to meet the needs of specific populations, such as those who are also physically disabled. The Commission recommends more research to ensure that proper care is given to this unique population.

### **Co-Occurring Mental Illness and Addiction**

According to the US Department of Health and Human Services, the term *dual diagnosis, or co-occurring disorders* is a common term that indicates the simultaneous presence of two independent medical disorders.<sup>133</sup> Recently, within the fields of mental health, psychiatry, and addiction medicine, the term has been popularly used to describe the coexistence of a mental health disorder and a substance abuse disorder.

Substance abuse is a common and devastating disorder among persons with severe mental illness (SMI). “Dual disorders occur in about 50 percent of individuals with SMI and is associated with a variety of negative outcomes, including higher rates of relapse, violence, hospitalization, homelessness, and incarceration.”<sup>134 135</sup> According to the National Alliance on Mental Illness (NAMI), “persons with a co-occurring disorder have a statistically greater propensity for violence, medication noncompliance, and failure to respond to treatment than consumers with just substance abuse or a mental illness.”<sup>136</sup> In many cases mental health programs and services are not prepared or able to handle individuals with both a mental illness and substance abuse disorder. Often substance use disorders come out of mental illness due to the environment in which a mentally ill individual lives. Mentally ill individuals tend to live in low-income environments with little social support and easy access to drugs and alcohol.<sup>137</sup>

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The statistics on the dual diagnosis population are startling. For example, 42.7 percent of individuals with a 12-month addictive disorder had at least one 12-month mental disorder, and 14.7 percent of individuals with a 12-month mental disorder had at least one 12-month addictive disorder.<sup>138</sup> Studies have also found that individuals with severe mental disorders were at significant risk for developing a substance use disorder during their lifetime. Individuals with schizophrenia are more than four times as likely as the general population to have a substance abuse disorder.<sup>139</sup> Further, individuals with bipolar disorder are more than five times as likely as the general population to have a substance abuse disorder.<sup>140</sup>

In many cases individuals classified with dual diagnosis struggle to obtain the services needed to support both disorders. According to the Massachusetts Executive Office of Health and Human Services (EOHHS) “an individual with a substance abuse problem is eligible for continuing care services if he or she is determined to have a qualifying mental disorder, meets impairment and duration criteria, requires DMH continuing care services, and has no other means for obtaining them. The qualifying mental disorder must be confirmed before assessing whether the applicant meets duration and functional impairment criteria. The individual may need substance abuse services in addition to mental health services.”<sup>141</sup>

It is generally understood amongst the treatment community that treatment programs designed for people whose problems are primarily substance abuse are generally not recommended for people who also have a mental illness. These programs tend to be confrontational and coercive and most people with severe mental illnesses are too fragile to benefit from them. Heavy confrontation, intense emotional jolting, and discouragement of the use of medications tend to be detrimental. These treatments may produce levels of stress that exacerbate symptoms or cause relapse.”<sup>142</sup>

There are a variety of programs in Massachusetts that attempt to handle dual diagnosis patients in a way to better enable the success over the disease. “Desirable programs for this population should take a more gradual approach. Staff should recognize that denial is an inherent part of the problem. Patients often do not have insight as to the seriousness and scope of the problem. Abstinence may be a goal of the program but should not be a precondition for entering treatment. If dually diagnosed clients do not fit into local Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups, special peer groups based on AA principles might be developed.”<sup>143</sup>

Massachusetts the programs who received grants from the US Department of Health and Human Services offer services designed for individuals with co-occurring disorders is listed below.

- **Henry Lee Willis Community Center**, Worcester, Massachusetts – \$400,000 each year for five years to address the needs of person 16 years of age and older who are chronically homeless and have mental illness and/or physical disability and substance abuse problems.
- **Casa Esperanza**, Roxbury, Massachusetts – \$400,000 for five years to develop aftercare services for persons of the Latino population in an existing residential treatment program.
- **Boston Medical Corporation**, Boston, Massachusetts – \$589,304 per year for three years, to support the BMC ACCESS Project that will work with the Massachusetts Department of

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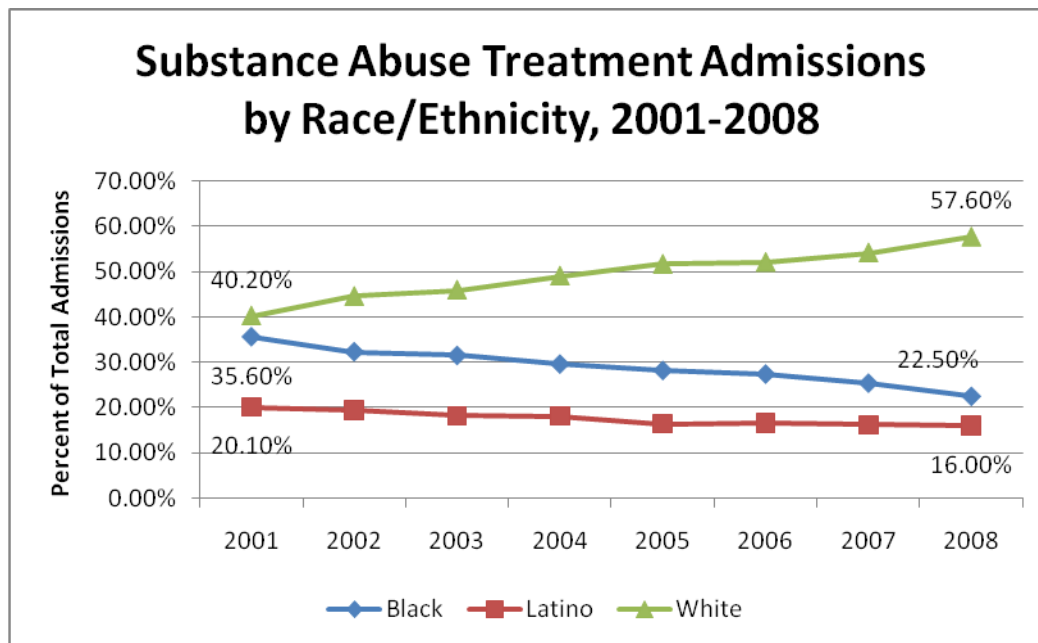
Mental Health to create an enhanced safe haven shelter for homeless persons providing mental health, substance abuse and primary care services.

- **ServiceNet, Inc.**, Northampton, Massachusetts – \$534,846 per year for three years, to support the Integrated Sheltering and Treatment Program to address the complex needs of homeless adults struggling with co-occurring mental health and substance abuse disorders.<sup>144</sup>

While these programs are good initial steps in improving services to those classified as dual diagnosis, more must be done to increase understanding of these multi-layer disorders. The Commission would recommend implementing lessons learned from the SAMHSA Co-Occurring State Initiative Grant (COSIG) that evaluated how 17 states addressed the common problem and developed more effective ways to identify and treat individuals with co-occurring mental illness and addiction (dual diagnosis). This effort would require a joint plan between the Department of Mental Health and the Bureau of Substance Abuse Services.

### **Cultural Competencies**

According to the 2000 U.S. Census 12.2 percent of Massachusetts residents are foreign born and 18.7 percent of all Massachusetts residents speak a language other than English at home.<sup>145</sup> Obviously then, Massachusetts possesses a significant population for whom English is not their first language and who, potentially, have limited English proficiency. There are many cultural, racial and ethnic differences that drastically change effective treatment for each subgroup of individuals. In 2007, the Latino population in Boston had the highest substance abuse mortality rate among all the racial/ethnic groups. In fact from 1999 to 2007, the Latino rate increased more than 500 percent.<sup>146</sup> It is important to note that the rate for African American and Caucasian populations decreased 20.3 percent and 8.3 percent, respectively, from 2006 to 2007, but those decreases are still well above the 1999 levels for mortality.<sup>147</sup> The Bureau of Substance Abuse Services provides interpreter services for those individuals in need of translators. For many people culturally appropriate treatment is an important piece of the continuum of care for substance abuse treatment.



Health of Boston 2009. Boston Public Health Commission. Research and Evaluation Office. Boston, Massachusetts. n.d. Print.

Casa Esperanza in Roxbury is a model in Massachusetts seeing initial success. By creating a situation where everyone speaks and understands the same language one eliminates the possibility that an incorrect translation might occur or that some misunderstanding could take place. Perhaps more importantly though eliminating the need for a third party—a translator—allows for treatment provider and client, and for the clients themselves, to interact naturally.<sup>148</sup> While this is an obvious benefit to non-English speakers there are some unintended consequences to factor in. Allowing for natural interactions to take place has several benefits in and of itself, most intuitive but some not. First, placing individuals with substance abuse disorder who speak the same language exclusively into the same facility could lead to charges that members of that community are being ghettoized. While this obviously would not be the intension of such a program there is no doubt that it could possibly be an unintended consequence. Second, one has to be concerned that in increasing the availability of treatment services for a specific language population the total number of beds would remain the same and treatment for individuals with a substance abuse disorder who are not a member of a minority language population would have a more difficult time finding a treatment bed; in short creating magnet centers de facto decreases the number of bed available, and the flexibility of those beds, for the majority of those seeking substance abuse treatment. The Commission recommends that further funding be given to the current programs in place that support cultural competency.

## Veterans' Concerns

The Commission believes that veterans are a demographic increasingly at risk for substance abuse. To date, Massachusetts has over 430,000 veterans throughout the state, including 30,000 veterans from Operation Enduring Freedom and Operation Iraqi Freedom.



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The Commission found that substance abuse is most often related to Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI) or other mental health issues in veterans. The Massachusetts Department of Veterans Services' (DVS) Statewide Advocacy for Veterans Empowerment Program (SAVE) issued a report finding that approximately 4 percent of veterans admitted to problems of substance abuse coupled with PTSD, TBI or other issues.<sup>149</sup> However, the percentage only reflected veterans who had self-identified substance abuse and mental health issues. Current service members are facing an increased number of deployments as compared to older veterans. DVS notes that there has been increased concern over service members who may not report mental health issues or an increase in symptoms and will instead turn to self-medication through substance abuse.<sup>150</sup>

Veterans dealing with PTSD and related issues reported most often abusing narcotics (specifically heroin and morphine), alcohol and marijuana. Outreach coordinators with the SAVE program have also seen an increased number of veterans abusing both their own and other's prescription drugs to cope with lingering mental health issues.<sup>151</sup>

The Statewide Advocacy for Veterans Empowerment Program is Massachusetts' leading advocacy program for veterans suffering from mental health issues. SAVE was created in 2008 as collaboration between DVS and the Department of Public Health and offers outreach, advocacy and referrals for veterans and their families. Their main focus is on issues facing returning veterans such as PTSD, TBI and mental health issues, substance abuse issues and suicide prevention.

Program coordinators track and refer veterans to the proper resources for the issues they are facing. SAVE notes that substance abuse is most-often occurring in conjunction with other mental health issues and is not isolated to veterans of current conflicts. It is important to note that DVS does not offer specific treatment options for substance abuse but rather has the SAVE program direct veterans to other state and local resources who can properly help them.

The Commission recommends continued funding support for veterans outreach, referral services, and the Department of Veterans Services. In order for this recommendation to be effective the Commonwealth must continue to improve upon its methods for identifying returning veterans so that they may benefit from the services available to them. Massachusetts offers some of the most comprehensive benefits and services to veterans and should continue to set an example for the rest of the country through effective veteran advocacy and recognition of the issues facing returning service members.

### ***CORI/Job Training***

Today in Massachusetts approximately 2.8 million people have records in the Criminal Offender Record Information (CORI) system.<sup>152</sup> Many former offenders have trouble finding employment, securing housing or taking out loans because they have criminal records. The lack of opportunity provided to ex-offenders and the stigma of having a CORI leads many to fall back into old habits, which often include addiction and limits their ability to put their lives back together. An integral part of recovery is reintroducing those who have recovered from addiction both into society and the job market. This process is stymied by the inability of former substance

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abusers to find work because of CORI offenses, even after they have shown that they are rehabilitated and are making every attempt to stay sober.

A parent of an individual with a substance abuse disorder testified at the Commission's hearing in Salem that when her son was unable to continue on a path of sobriety after going through a 30-day treatment program, she concluded that the best way to help her son was to have him arrested for a drug offense. Unfortunately, her son is now in jail and while he is on his way to recovery, she expressed remorse that she is the reason why her son is in jail and now has a criminal record for the rest of his life. The Commission recognizes that many families struggle with the decision of helping their children beat addiction, even if that requires incarceration and a CORI for life.

According to national studies, jails and prisons around the country are crowded with offenders who have substance abuse issues. Research has shown that 80 percent of offenders are either addicted to alcohol or drugs, or alcohol or drugs were involved in the commission of the crime.<sup>153</sup> Those who are in the Commonwealth's jails and prisons are not immune from this high level of substance abuse. According to state data, 20 percent of prisoners in Massachusetts are incarcerated because of a drug-related crime, and another 20 percent of defendants turned to crime to support a drug habit.<sup>154</sup>

To deal with the high rate of incarcerated substance abusers, the Department of Corrections offers a six to eight month program called the Correctional Recovery Academy (CRA), which targets substance abuse, anger management, criminal thinking and relapse prevention. However, the program's capacity does not come close to meeting its demand; the program has 552 inmates participating across seven facilities with a waiting list of 400 inmates. In 2007, only 48 percent of the releasing offenders eligible for the program attended.<sup>155</sup> The lack of support for the majority of incarcerated addicts is detrimental to the recovery process. Once offenders are let out of jail, their problems do not end. Often many employers will not hire a potential employee simply because they have a CORI. Ex-offenders currently have no way to prove they are rehabilitated, creating an undue burden for the rest of their lives.

The Commission recognizes that CORI reform is a major issue that must be addressed. Therefore, the Commission recommends increasing funding of the CRA and other programs that focus on treatment and reentry. The Department of Correction recommends that increasing the CRA by 240 beds would cost approximately \$900,000.<sup>156</sup> The additional funding will save money by preventing future incarcerations for minor drug offenses, which at \$47,679 per offender in fiscal year 2008, are a great burden on the state.<sup>157</sup> In addition to increasing funding, the Commission recommends that a program for Certificates of Rehabilitation and Recovery for offenders who complete correctional programs like the CRA be created and included in CORI reform legislation. A program such as this would enable ex-offenders to show prospective employers and landlords that they have gone through a recovery process.

Finally, the Commission recommends that when CORI reform takes place in the upcoming legislative sessions in the Commonwealth, the issue of better displaying individual crimes be examined. By allowing potential employers, landlords and other officials to see a clearer picture of an ex-offender's record, the hope is that the official would take into account a person's

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complete background. Further, such proposals as sealing CORI records for felonies and misdemeanors after less time would enable ex-offenders to get their lives back on track more quickly. The Commission expects that these incremental changes will provide those with CORIs who have chosen to continue on a sober path the opportunities they deserve.

### ***Family Issues***

Families traveled from across the state to each of the seven public hearings held by the OxyContin and Heroin Commission in order to testify and break the silence of this deadly epidemic. The members of the Commission received both written and oral testimony that openly and honestly spoke to the struggles and devastating effects that opiate use and abuse has had on the families living in the Commonwealth. The testimonies spoke to the uniqueness of each family's situation, yet provided a window into the similarities of the lives of the families living with the repeated heartache and devastation caused by opiate addiction. The Commission recognizes that addiction is a family disease and recovery is a family process. It is important for families to be both educated on the illness and supported throughout the recovery process as caring for a loved one who is struggling with an addiction is one of the most difficult situations that any individual or family will have to endure in their lifetime.

Throughout the public hearing process the Commission listened to heartfelt testimony from individuals who described the overwhelming experience of trying to blindly navigate through a system they knew little or nothing about to get treatment for an illness they knew just as little or nothing about. Many who testified admitted that they did not realize that a member of their family was addicted or that they didn't see any of the signs until there was a crisis that brought it to the forefront. At the July 10, 2009, hearing a mother spoke about her oldest son's addiction to heroin:

“Until three years ago my only exposure to heroin had been in the movies and popular culture. I had never known anyone who had used it, and never thought it would ever become a part of my reality. But it did.”

Many individuals stated in their testimony that they lived in an “idyllic” neighborhood, raised “good kids” and didn't know that such “hard” drugs were even being used or could be purchased within their community. National surveys of substance abuse, including the 1999 National Household Survey on Drug Abuse, “strongly suggest that most new users of heroin are young,” exemplifying the fact that today's opiate addict and opiate addiction cannot longer be confined to the old stereotypes of an older street addict lurking in the shadows of an urban high rise and shooting up in an alleyway.<sup>158</sup>

The Commission listened to individuals as they provided testimony detailing how painful and exhausting it was when discovering a loved one was addicted to opiates and the shame and isolation that followed. They described feeling embarrassed and that they were reluctant and scared to tell anyone about the situation. Their lack of information and desperation to do anything to help their loved one caused them to frantically search for answers, often times resulting with more questions and feelings of helplessness.

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The longer the addiction goes untreated, the higher the chance those members of the family who are not addicted will also develop destructive behaviors such as denial, enabling and co-dependency.<sup>159</sup> Research has shown that when an alcoholic or drug addict is progressing with the disease, the loved ones in their lives often become worse off than the addict themselves and suffer from emotional and psychological stress.<sup>160</sup> In addition, these individuals often suffer from physical problems such as headaches, allergies, insomnia, and cardiovascular disease.<sup>161</sup> At the July 10, 2009 hearing held in Hyannis, another mother spoke about needing treatment for not only the addict in her family but everyone in her family. She said that the support they received help them make some of the most difficult decisions they would have to make but it was, “the best thing we could have done, for it brought us to where we are today- recovery for not only for our son, but for the whole family.” Education and support for the family will bring much stability into the life of chaos that they are experiencing.

The Commission identifies that the role of the family needs to be valued and recognized in the delivery of drug treatment and has the following recommends:

- Increasing availability, access and funding to family services and peer support groups to ensure that families are given all options regarding treatment and services both for families and individuals with substance use disorder.
- Increasing access to information on drug overdoses so that parents and loved ones have the lifesaving tools in the event of an emergency.

*Increasing availability, access and funding to family services and peer support groups to ensure that families are given all options regarding treatment and services both for families and individuals with substance use disorder.*

The support and education received in this type of program provides a valuable tool for loved ones to cope with the different stages of addiction and recovery and have proved effective. These programs support family members in addressing their own unwarranted self-blame and alleviate the feelings of pain and suffering caused by the shame and isolation of this disease. Often times the isolation and stigma attached to addiction cause families to suffer in silence. Many family members find the support they need from the members who lead and participate in these groups; as they educate and involved loved ones and family members in the treatment and recovery process.

Local and national peer groups, such as Al-Anon, Nar-Anon, Learn to Cope, and the Massachusetts Organization for Addiction Recovery (MOAR) offer the friends and family members of individuals who are addicted a safe and supportive environment to learn about the disease, care for their loved ones, and themselves. The 2006 Al-Anon Family Groups Member Survey stated that members were “significantly affected” by another person’s drinking. It was also reported that 82 percent of the responders stated that their attendance and participation within the group much improved their mental health, 58 percent reported “much improved” overall health status and 73 percent reported “much improved” daily functioning at home, school and work.<sup>162</sup> These groups offer individuals who feel very much alone, a connection to those who have or are currently going through a similar situation and strength to carry on.

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*Increasing access to information on drug overdoses so that parents and loved ones have the lifesaving tools in the event of an emergency.*

Programs such as the Opioid Overdose Prevention and Reversal Project in the Commonwealth should be utilized to prevent dangerous overdoses. Further, parents and loved ones should be trained in administering Naloxone in the event of a opioid overdose. According to research, “death from a heroin overdose most commonly occurs 1 to 3 hours after injection, most deaths occur in the company of other people and that medical help is not sought or is sought too late.”<sup>163</sup> The estimated mortality rate in heroin overdoses managed at home is 10 percent.<sup>164</sup>

Beginning in Europe and Australia in the mid-1990s and moving to the United States in the 1999, naloxone is intravenous or intranasal prescription, with no abuse potential. Naloxone effectively blocks the opioids and restores normal breathing when used on an individual experiencing a drug overdose.<sup>165</sup> Currently, 11 communities participate in the pilot project in the Commonwealth. The Opioid Overdose Prevention and Reversal Project offers counseling and referrals to substance abuse treatment for all participants who are misusing opioids. These programs train opioid users, their families and their friends on how to prevent and recognize an opioid overdose, and what to do if one occurs.<sup>166</sup> In addition to training individuals on using the prescription naloxone, the programs cover the importance of calling 9-1-1, how to perform rescue breathing, how to administer nasal naloxone, and how to provide after-naloxone care.<sup>167</sup> The Commonwealth has seen some of the most promising results of any community using naloxone with enrollment to date in the program at over 3,000 with 350 reported reversals.

**Naloxone Prescription Programs in the United States 1999-2007**

<b>City/State</b>	<b>Year of Establishment</b>	<b>Number of Trainings/ Prescriptions</b>	<b>Number of Reported Overdose Reversals</b>
Chicago	1999	4600	416
New Mexico	2001	1312	222
San Francisco	2003	650	141
Baltimore	2004	951	131
New York City	2005	938	73
Massachusetts		3000	350

Sporer, Karl A. MD and Alex H. Kral, PhD. Prescription Naloxone: A Novel Approach to Heroin Overdose Prevention. *Annals of Emergency Medicine*. Vol. 49, No. 2: Feb 2007. 172-177.

These programs have proven effective and lifesaving in the communities they have been administered. Thus, the Commission recommends increasing funding to expand the current pilot program to a statewide program in all communities. At the Commission hearing in Fall River on May 15, 2009, Joanne Peterson, founder of Learn to Cope, set her prescription for Narcan out of the table as she began to testify and spoke about how she and other parents in the area carry Narcan in case they must use the lifesaving medication on an overdose victim. These individuals

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are well-trained in administering the drug and know the proper follow up steps to ensure a continuum of care. New Mexico saw a 20 percent decrease in overdose deaths after the state Department of Health began a naloxone distribution program in 2001.<sup>168</sup> The Commission recommends increasing access to this lifesaving program and providing continuing support to parents and families seeking use of Narcan and other similar drugs.

### ***Federal Issues***

In many ways the opiate epidemic in Massachusetts and around the country started at the federal level with the failure of the Food and Drug Administration to adequately monitor prescription medications. Federal issues are intertwined throughout many of the recommendations in this report; however, the Commission felt it necessary to include a separate section in the report on the specific issues that are beyond the purview. The following areas have been identified as key components to federal interaction with the Commonwealth in reaction to the opioid epidemic.

- Federal law enforcement and regulatory programs must be involved in the policing of illegal prescription drug activity on the internet.
- Mental health parity must be strengthened nationally to include provisions for substance abuse coverage by insurance companies.
- Continued and increased assistance from the Massachusetts Congressional delegation in obtaining funding for vital programs in the Commonwealth.
- Continued progress is necessary in regards to prescription medication monitoring through the Risk Evaluation and Mitigation Strategy (REMS) process at the Federal Drug Administration.

The Commission believes that for the state to be truly successful in combating the problem of addiction, coordination with the federal government is essential in the above areas. Swift action should be taken by the federal government to engage the state in capacity building measures and better equip the state to handle the opioid epidemic the state is facing.

*Federal law enforcement must be involved in the policing of illegal prescription drug activity on the internet.*

As was mentioned in the Interdiction section of this report, internet monitoring is acknowledged as a federal issue with little state interaction. The federal government is best equipped to take steps to counteract the illegal prescription market online. The Drug Enforcement Administration, along with the American Medical Association and state boards of medicine and pharmacy have all condemned the illegal activity of filling a prescription through so-called “cyber doctors.”<sup>169</sup> While many individuals use the internet to legally obtain prescriptions at a lower cost, the internet has become an increasingly dangerous place to purchase prescription pain relievers. Unreliable suppliers, faulty dosages, expired medication and lack of warnings and directions all contribute to this faulty industry. The Commission therefore recommends that

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federal law enforcement increase their involvement in internet policing for illegal narcotics prescription websites and that more federal dollars go towards this important program.

*Mental health parity must be strengthened nationally to include provisions for substance abuse coverage by insurance companies.*

Nationally, mental health parity lagged behind those of individual states. In 1996, President Bill Clinton signed the first federal legislation to require mental health benefits, prohibit the use of special annual and prohibit lifetime dollar limits on coverage for services associated with mental health.<sup>170</sup> The bill was reauthorized most recently in 2007. The law does not explicitly list substance use disorder and a mandated benefit or mandated offering, but rather instructs the Comptroller General to issue a study on the implementation of a mandated substance abuse treatment requirement for insurance companies. At this time it is unclear about any potential changes to the legislation that may occur to include substance abuse in the definition of mental health parity.

*Assistance from the Massachusetts Congressional delegation in obtaining funding for vital programs in the Commonwealth.*

Better coordination with the Massachusetts Congressional delegation, officials in Massachusetts must acquire the resources for innovative programs such as jail diversion and recovery high schools. The Commission believes that the Commonwealth could greatly benefit from additional funding and resources from the federal government, especially in the areas of treatment and prevention. The Obama Administration is developing a new model for drug addiction policy in the United States and there is evidence showing that the focus is on treatment and prevention measures. As this process continues, the state must concentrate on harnessing the possible new federal dollars in these areas to improve current programs and install new ones.

*Continued progress is necessary towards prescription medication monitoring through the Risk Evaluation and Mitigation Strategy (REMS) process at the Federal Drug Administration.*

In 2007, the Food and Drug Administration (FDA) was given the authority to assess drug and biological products for the risks they pose to those taking them. Additionally, the FDA was given the authority to use the Risk Evaluation and Mitigation Strategy (REMS) to deem a drug unsafe and issue regulations on the proper use of the medication. This year the FDA issued new guidelines regarding the re-evaluation of certain opioid drug products previously approved by the federal guidelines. A total of 24 products were called in for evaluation, including Hydromorphone, OxyCodone, Fentanyl and Methadone. The FDA is planning on holding a series of public meetings regarding prescription medication safety, some of which have already occurred, with the hopes of issuing new guidelines for the medications later this year. This process is essential to the original intent of the FDA and will ensure that the FDA is mitigating risk of these powerful prescription medications.

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The Commonwealth must engage the Congressional delegation at all levels in the reform process and ensure that as the Commission moves forward with policy recommendations the federal government is kept involved.

## **Conclusion**

Throughout the many hours of Commission testimony and conversations with citizens in the Commonwealth who deal with substance abuse on a daily basis, it is evident to the Commission that more must be done to provide for this vulnerable and often overlooked population. The face of addiction has drastically changed in the last 30 years and no longer is an individual with substance use disorder one who should be shunned and pushed to the bottom of the list for adequate services.

Each day in the Commonwealth, two citizens die of an opioid-related overdose. This statistic is a call to action for the state to reconsider long-standing policies surrounding substance abuse and treatment.

We are faced with a public health crisis. Like any other public health emergency, whether the pandemic influenza infection of the early part of the last century, the polio epidemic of the 1950's, the HIV/AIDs health crisis, or the rapid spread of H1N1 influenza we face today, resources must be allocated to minimize the scourge that is substance abuse disorder and, specifically, opiate abuse and addiction. Unlike some of these crises, there is no vaccine or medication that offers hope of elimination. We must concentrate our efforts at every interstice where we can lessen the impact of this dreaded disease.

In addressing the opiate epidemic the one thing we do understand is that there is not a one size fits all solution. The treatment community is divided between two philosophies. Those who believe in medication assisted treatment, such as methadone and buprenorphine/suboxone, and those who believe in abstinence. While there are merits to both sides, and the Commission does not endorse one mode of treatment over another, as long as there is evidence that supports a specific mode of treatment or a method of prevention, it must be considered. The Commission has suggested an ambitious set of recommendations for the Commonwealth to adopt and while the policy process can be tedious at times, we must continue to fight for the individuals who are suffering from the deadly disease of addiction.



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The Commission would like to thank the hundreds of individuals who wrote in, attended Commission hearings and made phone calls to express their views regarding policy recommendations. The Commission would especially like to thank the parents and loved ones who courageously told their stories to the Commission and did their part to break down the stigma surrounding substance use disorders.

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Department of Health and Human Services –	Senator Fredrick Berry
MassHealth	Senator Benjamin Downing
Boston Public Health	Senator Jennifer Flanagan
Boston Police Department	Senator Joan Menard
Office of the Police Commissioner – Boston	Representative Elizabeth Malia

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